



Child Deaths

2016 Annual Report

Learning to improve services



A note about this report

A number of stories, based on real families, are used in this report to draw attention to important learning for practitioners and families about child safety. Names have been changed for privacy reasons. These stories might be confronting for readers. In particular, Aboriginal communities might find some of the report's findings and stories about Aboriginal children distressing. A list of support and counselling services is provided at Appendix 1 of this report.

Contents

| | |
|---|-----------|
| List of figures and tables | 4 |
| Minister’s foreword | 5 |
| Secretary’s foreword | 6 |
| Executive summary | 7 |
| Child deaths in 2016..... | 7 |
| FACS response following the death of a child..... | 8 |
| Improving the way FACS works with children and families..... | 8 |
| Chapter 1: Child deaths in context | 9 |
| 1.1 Child protection in NSW..... | 9 |
| 1.2 Examining child deaths..... | 9 |
| Chapter 2: Child deaths in 2016 | 15 |
| 2.1 Child deaths in NSW in 2016..... | 15 |
| 2.2 Circumstances of child deaths..... | 16 |
| 2.3 Characteristics of the children..... | 25 |
| 2.4 FACS response to the children who died in 2016..... | 27 |
| Chapter 3: Responding to a child death | 31 |
| 3.1 Understanding the role of key agencies in child death investigations..... | 31 |
| 3.2 Understanding the impact of child deaths..... | 35 |
| 3.3 Assessing safety after a child death..... | 37 |
| Chapter 4: Improving the way FACS works with children and families | 45 |
| 4.1 Their Futures Matter..... | 45 |
| 4.2 Permanency Support Program..... | 47 |
| 4.3 Review of Aboriginal children and young people in out-of-home care..... | 50 |
| 4.4 NSW Practice Framework..... | 51 |
| References and further reading | 54 |
| Appendix 1: Counselling and support services | 59 |
| Appendix 2: Children’s understanding of death | 60 |
| Glossary | 61 |

List of figures and tables

List of figures

- Figure 1:** Children who died in 2016 and were known to FACS, by circumstances of death
- Figure 2:** Children who died in NSW, by number of total deaths and whether they were known to FACS, 2010–2016
- Figure 3:** Children who died in 2016 and were known to FACS, by circumstances of death
- Figure 4:** Children who died in 2016 and were known to FACS, by age
- Figure 5:** Children who died in 2015, by selected primary reported issues in ROSH reports received about them and their families
- Figure 6:** Sibling safety assessments in 2015 and 2016 by cause of death and child taken from parents' care
- Figure 7:** The NSW Practice Framework

List of tables

- Table 1:** Children who died between 2013 and 2016 and were known to FACS, by circumstances of death
- Table 2:** Children who died from an illness and/or disease between 2013 and 2016 and were known to FACS
- Table 3:** Babies who died suddenly and unexpectedly between 2013 and 2016 and were known to FACS
- Table 4:** Babies who died from conditions related to their premature birth between 2013 and 2016 and were known to FACS
- Table 5:** Children who died by suspected suicide between 2013 and 2016 and were known to FACS
- Table 6:** Children who died in a motor vehicle accident between 2013 and 2016 and were known to FACS
- Table 7:** Children who died from drowning between 2013 and 2016 and were known to FACS
- Table 8:** Children who were living in out-of-home care when they died between 2013 and 2016

Minister's foreword

This year's report reflects the stories of 94 children and young people who died in NSW in 2016 and who were known to the child protection system.

The death of any child is a tragedy and is deeply felt by the families and communities that loved them. I extend my deepest sympathies to all families that have lost children. It is also a very troubling time for the community, who are naturally shaken and seek answers from government.

Each year Family and Community Services (FACS) reviews its work with the children who were known to the department, to reflect on its role with the families of the children who died, and to consider where we could have done better.

This is our seventh year publishing this report, where we openly share our learning with the public, our inter-agency partners, and all who have a role to play in providing services for and improving the lives of children, young people and their families.

Within this year's report, Chapter 3 focuses on FACS role, alongside agency partners, in responding to child deaths. While very few child deaths each year are caused by the deliberate act of a parent or carer, we still have an important role in trying to understand where our work with vulnerable families can be better and where families, who are dealing with the loss of a child, are best supported.

The NSW Government remains committed to improving services that can make a difference to the lives of children every day through its major reforms of the child protection and out-of-home care system. In October this year we launched the Permanency Support Program, one of the most significant reforms to the out-of-home care system in NSW in decades. It is my firm belief this will lead to more children having a loving, permanent home for life, whether with his or her parents, extended family or kin, or through open adoption or guardianship.

I present this year's report to you with pride in the FACS workforce and I encourage you to read it. Very many of the reviews this year were enhanced by child protection practitioners who reflected on the work they did with the family, which has added to a richer understanding of how we can improve service delivery. We need to ensure this reflection continues and I thank our practitioners for their frankness.

Since returning as Minister for Family and Community Services, I have met with many practitioners who work every day in communities supporting vulnerable families, always with children's best interests at the heart of their practice. This is not easy work, it takes unwavering courage to advocate for children, and I am grateful that our community has such a dedicated FACS workforce.

Pru Goward

Minister for Family and Community Services

Secretary's foreword

Of all the reports I read each year, the FACS *Child Deaths Annual Report* is always the most challenging. It causes me to reflect deeply on the work we do, the families we help and the services we offer, and to ask how we can do better. It fills me with deep sadness for the children and young people who have died and their families and communities.

Feeling sad is a natural response to this report. What's important is the need for that sadness to galvanise our courage to ask ourselves whether our work was good enough and to be open to hearing and changing when it wasn't. We owe it to those children, young people and their families to do so, and to continue to work together across the government and non-government system for genuine and open critique.

This year's report is about the 94 children and young people who died in 2016 and who were known to the NSW child protection system. It describes information about how children and young people died, and illuminates practice challenges and system responses.

The child death reviews I have read over the past year have been a sobering reminder of the responsibility and value of quality child protection work. I am proud of our reviews – the rigor and care with which the reports are written, and the very high standard that we, as an agency, hold ourselves to. I have also been heartened by the generosity of practitioners who have openly shared information about the challenges of their work.

In September this year I launched the *NSW Practice Framework*. It is world class – setting out the values, standards, approaches and principles that guide our work with families, and providing role clarity and inspiration. It is based on evidence about what works in contemporary child protection practice. I am hopeful it will unite and revitalise our practice. You can see more about the framework in Chapter 4.

To the families and communities who have lost children, I am deeply sorry for your loss. To the practitioners who work every day to keep children safe, I thank you for your compassion, tenacity, skill and good practice – and your continued efforts to improve our response to vulnerable families.

Michael Coutts-Trotter
Secretary

Executive summary

The *Child Deaths 2016 Annual Report* is the Department of Family and Community Services (FACS) seventh public report examining FACS involvement with the families of children and young people¹ who died and were known to the department.

This report aims to provide context about the deaths of children who were known to FACS with the intention to strengthen the child protection system and improve child protection practice, as well as support other services working with vulnerable children and families. As this report is publicly available, there is the hope that it enhances community understanding of the complexities of the work, including how widespread social disadvantage is among the families the child protection system comes into contact with, and the very real consequences of this for children's experiences of abuse and neglect.

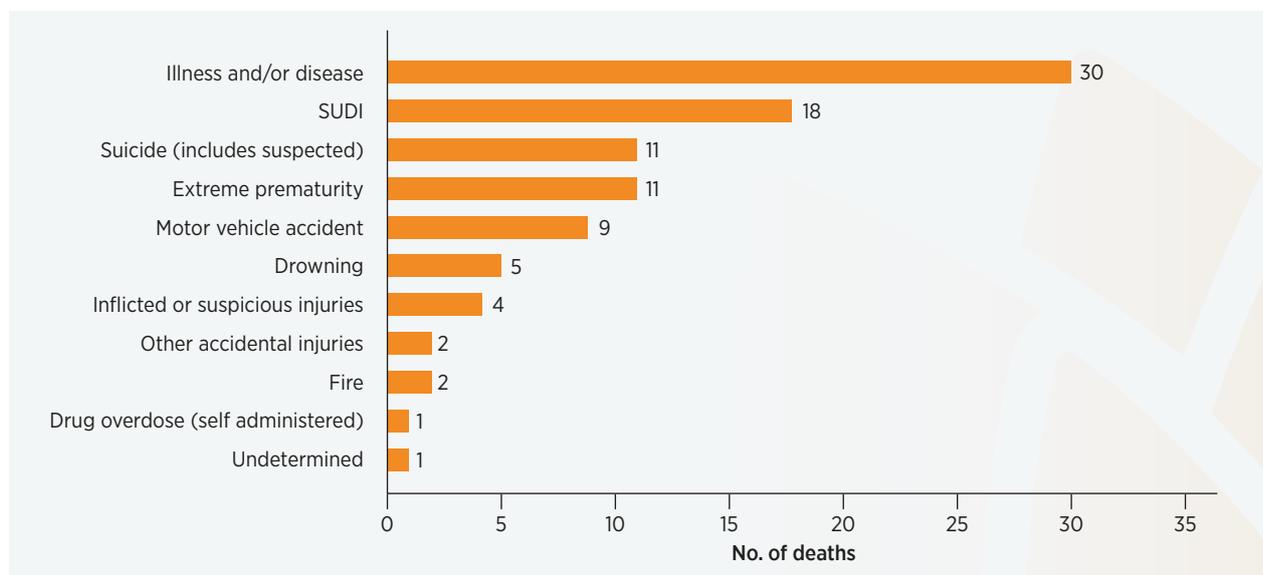
Child deaths in 2016

Chapter 2 of this report summarises information about the 94 children and young people who died in 2016 who were known to FACS.² As shown in Figure 1, most of the children died in circumstances related to illness and/or disease, or died suddenly and unexpectedly in infancy (SUDI)³.

Most of the children (74 children, or 79 per cent) who died in 2016 were the subject of a risk of significant harm (ROSH) report within three years of their death. Twenty of the 94 children (21 per cent) who died in 2016 were not the subject of a ROSH report, but their sibling was the subject of a ROSH report prior to the child's death.

Ten children were living in out-of-home care (OOHC) at the time of their death. Two of these children were living in the parental responsibility of their relative and eight children were living in the parental responsibility of the Minister for Family and Community Services. Of those eight children, two were placed with extended family, two were living independently and four were living with authorised non-government carers.

Figure 1: Children who died in 2016 and were known to FACS, by circumstances of death⁴



¹ The *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a child as aged under 16, and a young person as aged over 16 years and under the age of 18 years. For the purposes of this report, the terms 'child' and 'children' are used to refer to both children and young people.

² 'Known to FACS' includes children and young people (or their sibling/s) who were the subject of a risk of significant harm (ROSH) report within three years of death. This also includes where a child was in out-of-home care (OOHC) at the time of their death.

³ For further information about SUDI, see Section 2.2.2 of this report.

⁴ The 'undetermined' category includes cases where post-mortem information has not yet been received and where the Coroner has been unable to determine a cause of death.

FACS response following the death of a child

The focus of Chapter 3 in this year's report is about FACS responses to families following the death of a child.

The death of a child is profoundly distressing for parents and other family members. Whether the death is anticipated for medical reasons, unexpected and sudden, or caused by the intentional act of another, it can create intense emotional responses for families and the professionals involved.

When a child dies it can be complicated for families with children who have been previously reported at ROSH. Such families may be more likely to be disadvantaged and present with a range of vulnerabilities such as unemployment, homelessness, mental health issues and problematic substance use.

The chapter explores the complexities of balancing FACS dual role of assessing safety and supporting the family following a child death.

Improving the way FACS works with children and families

Chapter 4 of this report outlines current and future initiatives that seek to strengthen the child protection system. During 2016 and 2017 the NSW Government continued to implement major reforms of the child protection and OOHC system. These changes are described in *Their Futures Matter*, the government's long-term strategy for improving outcomes for vulnerable children and families in NSW. The reforms are aimed at ensuring positive change and creating an accountable system, in which sustainable needs-based support is provided to children and families. The NSW State Budget 2017–18 invested \$1.9 billion to protect and support NSW's most vulnerable children and families, and Chapter 4 describes some of these funded initiatives and new support models.

Sitting alongside the government's reform agenda, the Office of the Senior Practitioner has taken the opportunity in 2017 to update the *NSW FACS Care and Protection Practice Framework* – now renamed the *NSW Practice Framework*⁵ – to articulate FACS approaches and principles in our work with vulnerable families. The *NSW Practice Framework* provides an integrated reconceptualisation of the values, standards, tools and rules that guide the NSW statutory child protection system. The new framework also better complements the focus of *Their Futures Matter* in providing support to vulnerable children and families based on their needs and working collaboratively with other agencies to meet those needs.

⁵ See NSW FACS (2017).

Chapter 1: Child deaths in context

This chapter sets out the objectives of the report, and outlines the context of the child protection system and processes for child death review and oversight in NSW. This helps the public and other agencies to understand the issues underlying child abuse at a societal level.

1.1 Child protection in NSW

The Department of Family and Community Services (FACS) is the statutory child protection agency in NSW. FACS works with other government departments, non-government organisations (NGOs) and the community to support families to keep children safe from abuse and neglect.

FACS practitioners work with some of the most vulnerable children and families in the community. Many of these families live with extreme disadvantage because of poverty, lack of access to services, parental unemployment, homelessness, social isolation and reduced access to education. Often families are living with the effects of parental problematic substance use, unaddressed mental health issues and domestic violence, all of which can place children at risk. These problems are clearly linked to child abuse and neglect and lead to many of the ROSH reports made about children in NSW.⁶

FACS is working hard to support good child protection practice that understands how social disadvantage and stressors associated with it are related to child abuse and neglect. This report shares some of the stories of families whose children have died, reflects on their experiences and considers how FACS could have worked with the families to reduce risk and create safety.

1.2 Examining child deaths

1.2.1 FACS child death reviews

Children in NSW with a child protection history have a higher mortality rate than those not known to FACS.⁷ Other jurisdictions across Australia have similar findings.⁸

While most children die from causes or in circumstances not related to the reasons for their child protection reports, the fact remains that children who have been reported to FACS at ROSH are at greater risk.

6 See NSW FACS (2016d).

7 See NSW FACS (2016a).

8 Previous contact with child protection services is often noted as a common factor in child death reviews. See AIFS (2016).

Each year the *Child Deaths Annual Report* has four objectives:

1. To boost transparency and accountability about child deaths by publicly reporting on FACS involvement with the families of children who have died.
2. To increase public trust and confidence in FACS by reporting on what has been learnt from child death reviews, and the improvements to practice and systems made as a result of this learning.
3. To inform the public about the complexity of child protection work and the broader context of socioeconomic disadvantage that can impact on outcomes for families.
4. To share learning from child death reviews with practitioners and inter-agency partners in other government and non-government departments.

Serious Case Review unit

The Serious Case Review unit (SCR),⁹ which sits within the Office of the Senior Practitioner (OSP), reviews FACS involvement with children who have died, and their siblings who were reported to be at ROSH within three years before their death. The unit also completes a review where a child was in care when they died.

These reviews consider how FACS systems at local and organisational levels impacted on practice with the families of children who died. The review process seeks to examine learning opportunities for practitioners who work with families by not only identifying areas for practice improvement, but also promoting good practice.¹⁰ This in turn can lead to broader systems improvements.

Making recommendations from serious case reviews

A Serious Case Review Panel meets quarterly to discuss complex reviews and make recommendations. The panel is made up of the Senior Executive from across FACS, which ensures input from multiple perspectives and ownership of recommendations at a wider level. The panel is overseen and monitored by the FACS Executive Board.

This collaborative approach aims to share responsibility for recommendations arising from reviews and promote widespread organisational learning and change. On average, the OSP reviews FACS practice with over 200 families each year. Approximately 90 of these are serious case reviews following a child death and over 100 are practice reviews by casework specialists. Many of the reviews result in recommendations by the OSP aimed at improving direct casework with the family; however, a small portion are complex reviews and have implications for state-wide practice and systems.

Practitioner support and consultation

When a child dies, SCR provides practical support to practitioners straight away so they can get on with the important job of offering and providing support to families, and assessing the safety of other children in the family. In many instances, SCR works with casework staff to understand contextual information and to reflect critically on practice. Despite this being an understandably difficult process for staff, SCR is continually impressed by the courage and openness shown by FACS practitioners in their obvious willingness to learn from a child's death.

In some circumstances when a complex review is completed, practitioners are given an opportunity to talk about their work with a family, including thoughts on any contextual factors or systemic issues they consider relevant. In these instances, SCR also provides practitioners with the opportunity to read the review and any critique of their practice.

The staff consultation process is essential because, when done well, it reduces the risk of the child's death negatively impacting future practice with other vulnerable children. It can also reduce staff defensiveness and ensure accurate information and robust analysis. If review processes are to lead to genuine learning

⁹ Formerly known as the Child Deaths and Critical Reports unit.

¹⁰ While child protection is what we do, practice is how we do it. Practice is the relationships, the conversations, the thinking and the care. When it works, practice is the magic that keeps children with family, connected to culture and cherished by those who love them best. See NSW FACS (2016c).

and practice/system improvement, and if they are to support staff to work differently with other children, then a process that allows staff the opportunity to understand what has been said about their work is crucial. If staff feel they have been consulted, they are more likely to accept the review findings, even those that are critical of practice. Consultation can also impact positively on the openness of other staff engaging with the review process in the future.

Learning from child death reviews

There is considerable learning from child death reviews, and the OSP shares learning proactively with practitioners across FACS. Some examples of the ways FACS learns from child death reviews are highlighted below.

Child deaths annual reports

These reports are published at the end of each calendar year, and provide information about children who have died, including their characteristics, the circumstances of their deaths, and how FACS responded to the families before and after their deaths. The reports aim to engage practitioners and the community in the stories of the children who have died, as well as highlighting the complexities of child protection work in NSW.

Cohort and other reviews

Each year SCR undertakes a cohort review that looks at a group of children who died and were known to FACS who share common statistical characteristics. Previous reviews include an analysis of the deaths of:

- children who experienced neglect (2015)
- vulnerable teenagers (2014)
- babies who died suddenly and unexpectedly (2013)
- children who were reported to be at ROSH because of domestic violence (2012)
- children who had young parents (2011).

This year SCR has completed a review of FACS responses to families when a child dies. The review focuses on assessing the safety of the child's surviving siblings and supporting the family.

Practice review sessions and other forums

The OSP often holds 'practice review' sessions with practitioners following a child death review. These sessions support practitioners to reflect on what worked, what could have been done differently and how learning could be applied to work with other families. The sessions also give staff an opportunity to share their expertise and insights about a family or about broader issues raised in a review.

The stories of children who have died are also at the heart of many broader OSP learning forums and often inform the OSP's Research to Practice seminars.¹¹

1.2.2 Public and inter-agency understanding of child deaths

In providing public information about the circumstances surrounding individual child deaths, FACS is committed to protecting the privacy of vulnerable families who are impacted by the death of a child.¹² The NSW Parliament has also responded by protecting privacy and confidentiality in a range of legislation that governs the disclosure of information on individual child deaths.¹³

While FACS cannot report publicly about individual children, we have a strong commitment to transparency and accountability. The annual publication of this report reflects this commitment.

¹¹ Each year the OSP offers a program of Research to Practice seminars to frontline workers and other professionals, to provide them with up to date research and the best of current practice on a range of child protection areas.

¹² Although information about children who have died is given in this report, the identifying details of the families have been removed to protect their privacy.

¹³ *Children and Young Persons (Care and Protection) Act 1998* (NSW); *Children (Criminal Proceedings) Act 1987* (NSW); *Privacy and Personal Information Protection Act 1998* (NSW); *Health Records and Information Privacy Act 2002* (NSW); *Privacy Act 1988* (Cwth).

Child deaths and the media

Every child death should be the subject of scrutiny and review. Drawing attention to the stories of vulnerable children and families can help the community to understand the nature of child protection work and some of the complexities involved in working with vulnerable families. If people have a better understanding of what life could be like for a child at risk, they may be more aware of and better able to help the child and report their concerns.

Every year a small number of child deaths are the subject of considerable media attention and scrutiny. These deaths often involve children who have died as a result of abuse by a parent or carer. Understandably, these stories spark strong reactions from the community. The media plays an important role in supporting the community to gain a better understanding of child deaths, however there remains an ever-present risk for the child protection system in the face of media scrutiny and the impact this may have on vulnerable children. The challenge is to ensure that, in the face of public demand for immediate change, the learning from the death of a child results in considered system reform. Professor Eileen Munro¹⁴ identified that:

‘A one-dimensional view, however, can impact on the child protection system in a way that makes it less safe for children. A lack of public confidence in child protection professionals can help create spikes in demand that social care teams struggle to cope with, making it more difficult to react quickly to the most serious of cases. Morale among child protection workers can also be damaged, leading to more workers leaving the profession and making it more difficult for the profession to attract candidates and retain skilled staff.’¹⁵

Review work by SCR has highlighted the impact that the death of a child can have on staff when there has been extensive coverage in the media. Practitioners may adopt a potentially unhelpful defensive response, leading them to become too cautious; or they may adopt an overly intrusive approach with families, and not recognise opportunities to build safety for a child within a family. Defensive practice can also paralyse the judgement of a practitioner and reduce their belief that families can achieve positive change.¹⁶

At an organisational level, the *NSW Practice Framework*¹⁷ helps leaders acknowledge the uncertainty of the work and share the risk between workers and management. The framework provides a foundation to support work with families and address core areas of work, including relationship-based practice, critical reflection, developing expertise and sharing risk. Within this framework, FACS child death review work acknowledges that reviews are one of many ways to create a culture of continual learning, which can encourage the department to reflect critically on practice and how the broader system impacts on the lives of children and families.

1.2.3 Child death oversight in NSW

FACS works closely with a number of agencies in NSW to support a strong system of oversight, investigation and review of child deaths. The NSW Ombudsman, the NSW Police Force, the NSW State Coroner and the Office of the Children’s Guardian all have responsibility for child death oversight, investigation and review.

NSW Ombudsman

The NSW Ombudsman is an independent oversight agency for all NSW public sector agencies. One of the roles of the Ombudsman is to review the deaths of children from suspected neglect or abuse or which occur in suspicious circumstances. The Ombudsman also reviews child deaths which have occurred in a care setting. The aim of this function is to review the causes and patterns of those deaths and identify ways they can be prevented or reduced. The Ombudsman must report to Parliament every two years. The last report of reviewable child deaths was tabled in July 2017.¹⁸

¹⁴ Professor Eileen Munro is a Professor of Social Policy at the London School of Economics specialising in child protection research.

¹⁵ See Munro (2011, p. 11).

¹⁶ See Turnell and Edwards (1999).

¹⁷ See NSW Family and Community Services (2017).

¹⁸ See NSW Ombudsman (2017).

NSW Child Death Review Team

The Child Death Review Team (CDRT) reviews the deaths of all children in NSW with the objective of preventing and reducing child deaths. The Ombudsman is the convenor of the CDRT. The team includes the Advocate for Children and Young People, the Community and Disability Services Commissioner, representatives from other government departments (including FACS) and individuals with expertise in relevant fields, including health care, child development, child protection and research methodology. The CDRT reports annually to the NSW Parliament about its work, including research projects.

The CDRT advised FACS that 461 children aged from birth to 17 years died in NSW in 2016. These figures differ from FACS data, highlighting important differences between FACS and CDRT:

- CDRT may also include NSW children who died in another state. However, where a child's death is registered interstate, the identity of the child may not be provided to the team and these deaths may be reported separately.
- CDRT reports include the 'child protection history' of children who die in NSW. Unlike FACS, however:
 - CDRT does not include children who died in care as having a child protection history unless the child and/or a sibling was the subject of a report to FACS within the three years prior to their death.
 - CDRT child protection history includes children who were reported to FACS but whose reports did not reach the statutory threshold of risk of significant harm, and also children who were known to Child Wellbeing Units.¹⁹

NSW Police Force and NSW Coroner

The NSW Police Force investigates child deaths where the circumstances of the death are suspicious or undetermined.

In addition, a senior coroner has the power to hold an inquest into a child's death where it appears to the Coroner that:

- the child was in care
- the child was reported to FACS in the three years immediately preceding their death, or was sibling of a child reported to FACS within three years preceding their death
- there is 'reasonable cause to suspect' that the child died in suspicious circumstances, or circumstances that may have been due to abuse or neglect.

FACS is responsible for reporting to the State Coroner the deaths of children known to the agency. FACS and the State Coroner's office also share information regularly about child deaths.

Domestic Violence Death Review Team

The Domestic Violence Death Review Team is convened by the NSW State Coroner. The team includes representatives from 11 agencies, including police, justice, health and social services, and representatives from the non-government and academic sectors.

The core functions of the team are to:

- review and analyse individual closed cases of domestic violence deaths²⁰
- establish and maintain a database to identify patterns and trends relating to such deaths
- develop recommendations and undertake research that aims to prevent or reduce the likelihood of such deaths.

¹⁹ The Child Wellbeing Units established in NSW Health, the NSW Police Force, and the NSW Department of Education help mandatory reporters in government agencies ensure that all concerns that reach the ROSH threshold are reported to the Child Protection Helpline. In other cases, they identify potential responses by agency or other services to help the child or family.

²⁰ Domestic violence deaths are defined in the *Coroners Act 2009* (NSW) as a death that is caused directly or indirectly by a person who was in a domestic relationship with the deceased person. The Act also provides that a domestic violence death is 'closed' if the Coroner has dispensed with or completed an inquest concerning the death, and any criminal proceedings (including appeals) concerning the death have been finally determined.

The death of a child in the context of domestic violence is subject to review by the team. The team's fourth report (2013–2015) was published in 2015. In 2016, the Domestic Violence Death Review Team moved to reporting every two years, with the next report expected to be published at the end of 2017.²¹

Children's Guardian

The primary functions of the Children's Guardian are to:

- accredit and monitor designated agencies that arrange statutory OOHC in NSW
- maintain and monitor the NSW Carers Register, a database of people who are authorised, or who apply for authorisation, to provide statutory or supported OOHC
- register and monitor agencies that provide, arrange or supervise voluntary OOHC
- accredit non-government adoption services providers
- authorise the employment of children under the age of 15, and child models under the age of 16, in the entertainment sector
- administer the Working With Children Check and encourage organisations to be safe for children
- administer the Child Sex Offender Counsellor Accreditation Scheme – a voluntary accreditation scheme for counsellors working with people who have committed sexual offences against children.

FACS is required to notify the Children's Guardian about the deaths of all children in statutory or supported OOHC.

1.2.4 Reviewing the deaths of children in out-of-home care

NSW has a particularly strong system of oversight into the deaths of children in OOHC. Where a child dies in OOHC, SCR reviews FACS involvement, the CDRT may look at the child's death, the death is reported to the Coroner and the Children's Guardian, and the death may be investigated by NSW Police and the Coroner, and reviewed by the NSW Ombudsman.

The NSW Ombudsman plays a significant role in examining the deaths of children who were in a care setting. This includes children placed with FACS or NGO carers and children who died in a facility funded, operated or licensed by the Ageing, Disability and Home Care division of FACS. These reviews consider the adequacy of the involvement of all agencies with the child and family up to the child's death, including when children have been placed with NGO authorised carers.

In response to the significant progress that has been achieved in moving statutory OOHC services from the government to the non-government sector, the SCR unit is working with non-government partners more often as part of the review process. The deaths of children in non-government OOHC settings have led to a broadening of review mechanisms, with some reviews being undertaken jointly and others separately. This flexible and collaborative model of review provides the opportunity for all services to consider their involvement with children and to share reflections and learning in order to improve service provision to benefit all children in care.

²¹ The Crimes (Domestic and Personal Violence) Amendment (Review) Bill 2016 assented on 28 June 2016.

Chapter 2: Child deaths in 2016

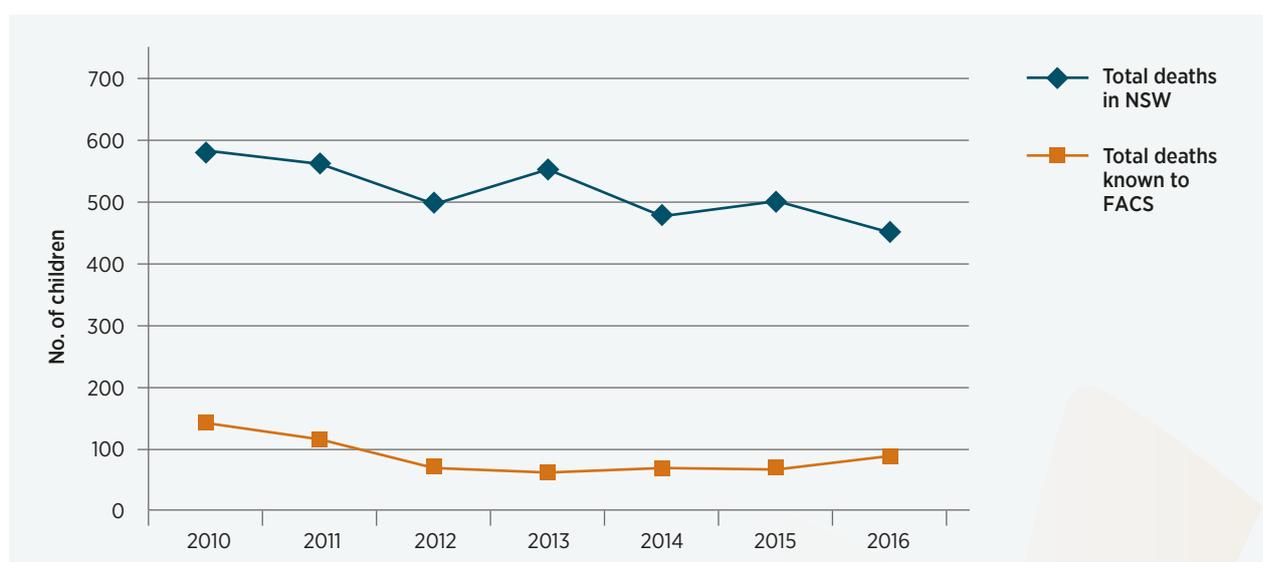
This chapter summarises information about the children who died in 2016 and who were known to FACS prior to their death. It includes characteristics of the children such as their age, gender and socioeconomic background. Analysis also considers the circumstances in which the child died, their child protection history and the response of FACS prior to and following the child's death.

The chapter provides context to the deaths of the 94 children who died in 2016 and while it cannot tell the full story of each of the children's lives, it aims to build a picture of the circumstances in which the children died and to reflect on any opportunities to improve FACS responses to the children and their families.

2.1 Child deaths in NSW in 2016

Between 1 January 2016 and 31 December 2016, the deaths of 461 children were registered in NSW.²² In the same period, 94 of the children who died were known to FACS because they were in care or had been reported at risk of significant harm (ROSH) in three years prior to their death, or their sibling had been reported at ROSH.

Figure 2: Children who died in NSW, by number of total deaths and whether they were known to FACS, 2010-2016²³



The number of deaths of children known to FACS increased in 2016 from the previous year.²⁴ However, since 2010 there has been an overall decline in the number of deaths of children who were known to FACS. The overall decline has previously and consistently been attributed to the introduction of the ROSH threshold, which was proclaimed on 24 January 2010.²⁵ This legislative change resulted in lower numbers of reports about children meeting the threshold for reporting to FACS.

There was an initial decrease in the number of ROSH reports to FACS but this trend started to reverse after 2012, when ROSH reports increased. Between 2013 and 2014, ROSH reports increased by over 10,000 reports; between 2014 and 2015, ROSH reports increased by over 2500 reports; and between 2015 and 2016, ROSH reports increased by just over 20,000 reports.

²² Information provided to FACS from the NSW Child Death Review Team in 2017.

²³ *ibid.*

²⁴ There were 79 deaths of children known to FACS in 2015.

²⁵ On 24 January 2010 the threshold for reporting to FACS changed from 'risk of harm' (ROH) to 'risk of significant harm' (ROSH).

The number of deaths of children reported at ROSH also declined initially after the legislative change and there has been a marginal increase in the number of deaths of children known to FACS since 2013.²⁶ Given the criteria for FACS serious case reviews includes children or their siblings who were the subject of a ROSH report within three years of their death, any increases in ROSH reports can impact on child death data.^{27 28}

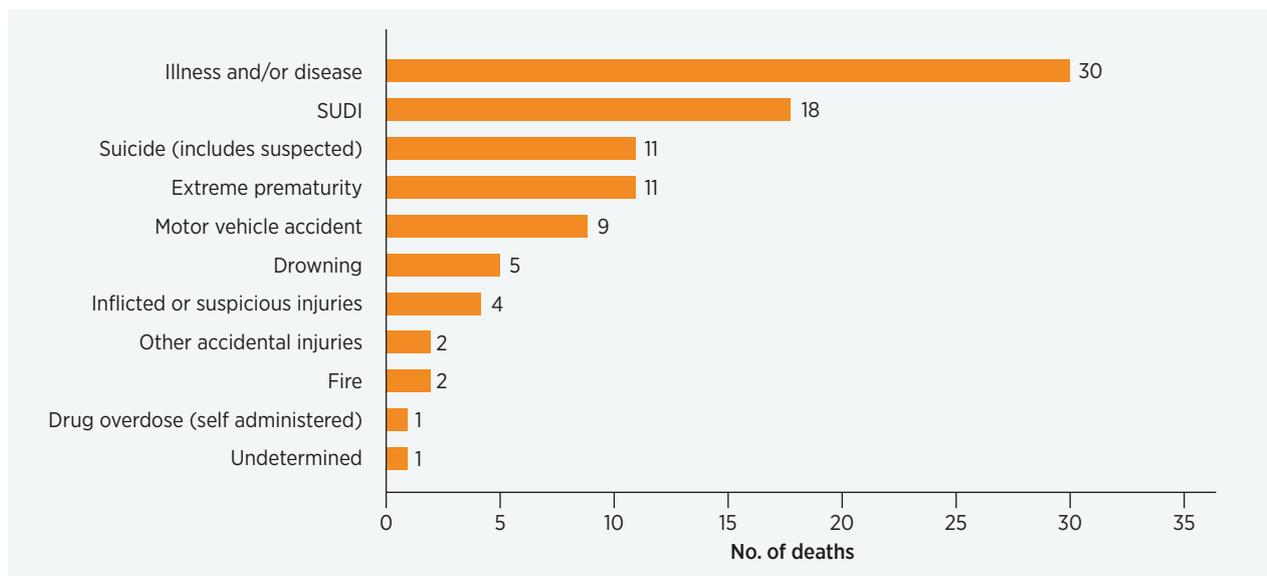
The 94 children who were known to FACS and who died in 2016 represents 0.11 per cent of the total number of children reported to FACS in 2016. This proportion is consistent with previous years' findings.²⁹

2.2 Circumstances of child deaths

FACS receives information about the medical cause and circumstances of a child's death from the NSW State Coroner and the NSW Ombudsman. FACS relies on these sources to report on the circumstances of the child's death. Following the death of a child, FACS completes a review of the department's work with a child and their family, including information from their child protection history and the work completed by practitioners. These reviews, along with the circumstances in which a child died, provide a context for FACS responses to the family.

Figure 2 describes the circumstances of death in which all children known to FACS died in 2016. Similar to previous years, most of the deaths in 2016 were associated with illness and/or disease and sudden unexpected death in infancy (SUDI).³⁰ This year, extreme prematurity and suicide were the third and fourth most common circumstances of death, followed by deaths from motor vehicle accidents.

Figure 3: Children who died in 2016 and were known to FACS, by circumstances of death³¹



The categories used to describe the circumstances of death may be different from those for cause of death. For example, the cause of death could be multiple injuries, but the circumstances of death may be suicide, motor vehicle accident or an inflicted or suspicious injury.

²⁶ Deaths of children known to FACS: 2013(75), 2014 (80), 2015 (79), 2016 (94).

²⁷ In 2016, FACS received 149,965 ROSH reports, involving 82,556 children. This was an increase from the previous year of 20,264 ROSH reports and 7210 children reported to FACS. In 2015, FACS received 129,701 ROSH reports, involving 75,346 children. This was an increase from the previous year of 2513 ROSH reports and 1320 children reported to FACS. In 2014, FACS received 127,188 ROSH reports involving 74,026 children. This was an increase from the previous year of 10,818 ROSH reports and 4859 children reported to FACS. In 2013, FACS received 116,370 ROSH reports involving 69,167 children.

²⁸ Information provided by the FACS Business Reporting Unit.

²⁹ In 2015 the number of children who died and were known to FACS (79 children) represented 0.1 per cent of the total number of children reported to FACS that year.

³⁰ For further information about SUDI, see Section 2.2.2 of this report.

³¹ The 'undetermined' category includes cases where post-mortem information has not yet been received and where the Coroner has been unable to determine a cause of death.

Table 1 compares the circumstances of death for children who were known to FACS who died between 2013 and 2016. Despite little change in the overall number of deaths in 2015 and 2016, the proportion of children who died in each category has changed in some areas. It should be noted that figures are subject to fluctuation across years due to the small numbers, therefore conclusions should not be drawn about these changes. Notable changes are:

- an increase in the number of children who drowned
- an increase in the number of children who died from suicide.

Table 1: Children who died between 2013 and 2016 and were known to FACS, by circumstances of death³²

| Circumstance of death | 2013 | | 2014 | | 2015 | | 2016 | |
|-----------------------------------|-----------|------------|-----------|------------|-----------|-------------------------|-----------|------------|
| | No. | % | No. | % | No. | % | No. | % |
| Accidental asphyxia | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 |
| Accidental choking | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Drowning | 3 | 4 | 5 | 6 | 1 | 1 | 5 | 5 |
| Drug overdose (self-administered) | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 |
| Extreme prematurity | 15 | 20 | 18 | 21 | 8 | 10 | 11 | 12 |
| Fire | 2 | 3 | 0 | 0 | 1 | 1 | 2 | 2 |
| Illness and/or disease | 22 | 29 | 27 | 34 | 29 | 37 | 30 | 32 |
| Inflicted or suspicious injuries | 2 | 3 | 3 | 4 | 4 | 5 | 4 | 4 |
| Motor vehicle accident | 6 | 8 | 3 | 4 | 10 | 13 | 9 | 10 |
| Other accidental injury | 1 | 1 | 0 | 0 | 0 | 0 | 2 | 2 |
| SUDI | 16 | 21 | 14 | 18 | 16 | 20 | 18 | 19 |
| Suicide (includes suspected) | 5 | 7 | 6 | 8 | 4 | 5 | 11 | 12 |
| Undetermined | 2 | 3 | 2 | 3 | 5 | 6 | 1 | 1 |
| TOTAL | 75 | 100 | 80 | 100 | 79 | 100³³ | 94 | 100 |

2.2.1 Deaths from illness and/or disease

Deaths from illness and/or disease account for the greatest proportion of child deaths in 2016. This is consistent with previous years. The information below provides further information about the circumstances and experiences of these children.

In 2016, 30 children (32 per cent) died from an illness and/or disease. While the number of children who died from an illness and/or disease increased slightly in 2016, the proportion to all children who died decreased (by 5 per cent), as shown in Table 2.

Table 2: Children who died from an illness and/or disease between 2013 and 2016 and were known to FACS

| | 2013 | 2014 | 2015 | 2016 |
|---------------|----------|----------|----------|----------|
| No. of deaths | 22 | 27 | 29 | 30 |
| % of deaths | 29 | 34 | 37 | 32 |
| Age range | 0-17 yrs | 0-17 yrs | 0-17 yrs | 0-17 yrs |

Of the 30 children who died from an illness and/or disease, information provided to FACS indicated that 25 of the children had been diagnosed with a medical condition³⁴ before their death and 11 of those children also had a diagnosed disability before their death.

³² Data may have changed from previous years' reports due to new information and changes in reporting methods.

³³ Similarly, data may have changed from previous years' reports.

³⁴ This figure is based on information known to FACS. It is possible that more children had an existing medical condition prior to their death that was not reported to the department.

The ages of the children who died from an illness and/or disease varied. Of the 30 children who died from an illness and/or disease, seven (23 per cent) died before they were 12 months of age. Nine children (30 per cent) were aged between one and four years, three children (10 per cent) were aged five to eight years and 11 children were aged between nine and 17 years. This differed from 2015 when 12 children who died were under the age of 12 months.

The causes of death for children with an illness and/or disease varied. Broadly they fell into two categories. Twelve of the children had severe disabilities and died as a result of health complications related to those conditions. The remaining 18 children died from other acute illnesses such as cancer, heart or liver failure, pneumonia and asthma among other causes.

Five of the children who died from an illness and/or disease were in the parental responsibility of the Minister when they died and one child was in the parental responsibility of relatives. Of the children in care, five had severe disabilities from birth or early in life and one child became sick with an acute illness while in care.

Our reviews identified consistently how the ongoing stressors associated with caring for a child with an acute illness or severe disability can exacerbate or lead to other child protection issues such as domestic violence, parental mental health and problematic drug and alcohol use, and the subsequent neglect of the child's medical, physical and emotional needs. This is critical for practitioners to consider when assessing safety and risk, and working with families and other agencies to create safety plans for children with complex medical needs. Of the children who died from illness and/or disease in 2016:

- For 19 of the 30 children (63 per cent), reports about neglect were received about the family prior to the child's death.
- For 9 of the 30 children (30 per cent), reports about domestic and family violence were received about the family prior to the child's death.
- For 12 of the 30 children (40 per cent), reports about parental drug and/or alcohol misuse were received prior to the child's death.

Our reviews also found that even experienced foster carers can face challenges in meeting the emotional needs of children with complex health issues. Caring for a child with a life-limiting illness who needs around-the-clock medical care and frequent hospital admissions can place stress on any carer. Ongoing case management and support to carers is vital to ensure that the child's medical needs do not preclude them from receiving love, nurture and stimulation to ensure quality of life.

Recognising the challenges faced by parents and carers helps FACS to understand and better support families to keep their children safe.

We found evidence of good practice in inter-agency work when making end of life decisions³⁵ about children in care. We also found evidence of good practice in working inclusively with birth families, foster carers and non-government OOHC agencies to ensure that all were involved in the decision-making when the child died.³⁶

FACS CASEWORK PRACTICE

For practitioners, the FACS Casework Practice intranet site provides information about the process and good practice involved in making end of life decisions for children in OOHC. See the practice mandate, *Health needs of children in OOHC*.

³⁵ End of life decision-making is sometimes needed when questions arise over whether to withhold or withdraw life-sustaining treatment at the very beginning of an infant's life, such as for extremely premature neonates, or infants with severe congenital conditions, or for younger and older children who may also suffer from health conditions or traumatic incidents which result in decisions about life-sustaining treatment. See QUT (2017).

³⁶ In situations where the child is subject to a care order and in the parental responsibility of the Minister for Community Services generally or specifically for medical decisions, the law treats the Minister as the child's parent. NSW Health requires clinicians to consult with FACS about those decisions. See Office of the Chief Health Officer (2016).

2.2.2 Sudden unexpected death in infancy

SUDI is a classification rather than a cause of death, and the definition of SUDI varies within Australia and internationally. The NSW Child Death Review Team defines SUDI as the sudden and unexpected death of an infant aged less than 12 months where the cause:

- is found after investigation (an explained SUDI)
- remains unidentified after all investigations are completed (an unexplained SUDI); this includes deaths classified as sudden infant death syndrome (SIDS).

In most circumstances, babies who die in circumstances of SUDI die after they have been placed to sleep.

Table 3 shows that in 2016 the deaths of 18 babies were classified as SUDI,³⁷ comprising 19 per cent of deaths of all children known to FACS for the year. Post-mortem reports were available for 12 of the 18 babies. The reports provide the following cause of death information:

- explained SUDI – accidental asphyxia (four babies), natural causes (three babies)
- unexplained SUDI (five babies).

Table 3: Babies who died suddenly and unexpectedly between 2013 and 2016 and were known to FACS

| | 2013 | 2014 | 2015 | 2016 |
|---------------|-----------|----------|-----------|-----------|
| No. of deaths | 16 | 14 | 16 | 18 |
| % of deaths | 21 | 18 | 20 | 19 |
| Age range | 0-10 mths | 0-6 mths | 0-11 mths | 0-11 mths |

Of the 18 babies who died suddenly and unexpectedly in 2016, one or more modifiable risk factors (characteristics in an infant's sleep environment) were found in 15 families (83 per cent). A modifiable risk factor increases the risk of SUDI. Risk factors include:

- prone sleeping (placing baby to sleep on their front)
- bed sharing
- exposure to smoking
- excess bedding or clothing
- bedding that is not designed for infants and/or sleeping
- soft pillows or other objects in the sleep environment.³⁸

Eight of the 18 babies who died in circumstances of SUDI were from Aboriginal families (44 per cent). Over the past several years the number of children from Aboriginal families who have died in circumstances of SUDI has fluctuated, but over the last two years it has remained comparatively high.³⁹

The high number of children who die suddenly and unexpectedly in infancy reiterates the need for practitioners to be sensitively attuned to the modifiable risk factors that can lead to SUDI, be clear in their messages to parents about safe sleeping and engage in ongoing training to keep their knowledge and skills up to date.

FACS CASEWORK PRACTICE

The FACS Casework Practice intranet site has a range of information and resources including a training package for practitioners about providing safe sleeping advice to families that incorporates culturally tailored advice.

³⁷ Information provided to FACS from the NSW Child Death Review Team in 2017.

³⁸ See NSW FACS (2016a).

³⁹ In 2015, 12 of 16 babies who died in circumstances of SUDI were from Aboriginal families. In 2013, three of the 14 babies who died in circumstances of SUDI were from Aboriginal families.

NSW Health and Red Nose also provide a range of resources for culturally and linguistically diverse and Aboriginal families and communities to highlight the risk factors for SUDI and to promote safe sleeping practices.⁴⁰

Culturally tailored community-based maternity care is provided in NSW under the NSW Aboriginal Maternal Infant Health Strategy (AMIHS). Care is provided during pregnancy and in the postnatal period up to eight weeks after the birth of a child.⁴¹ The aim of AMIHS is to improve health outcomes for Aboriginal women and non-Aboriginal women with Aboriginal partners during pregnancy and birth. The care is provided in a partnership model by midwives and Aboriginal health workers or Aboriginal health education officers and includes community development activities that provide a holistic approach to developing the health and wellbeing of the women and families using the services.

One of the ongoing challenges for practitioners working with families with a range of vulnerabilities is that messages communicated to parents about safe sleeping are not always received, understood or adopted. Where there are a range of parental risk factors, parents need to be supported to maintain practices that promote safety for their baby. This requires the practitioner to build a relationship with the family and in some cases the community around the child. It also highlights the need to be consistent, persistent and non-judgemental when talking to parents about safe sleeping. The OSP Clinical Issues Team is available for consultations to support practitioners to have conversations with parents about safe sleeping and to assess safety for a child where there are unsafe sleeping practices.

2.2.3 Deaths related to premature births

In 2016, 11 babies died from conditions related to their premature birth (12 per cent of all deaths of children known to FACS in that year), as shown in Table 4. Seven babies died at birth or within the first 24 hours after birth, and one baby died within the first month.

Table 4: Babies who died from conditions related to their premature birth between 2013 and 2016 and were known to FACS

| | 2013 | 2014 | 2015 | 2016 |
|---------------|----------|----------|---------|---------|
| No. of deaths | 15 | 18 | 8 | 11 |
| % of deaths | 20 | 21 | 10 | 12 |
| Age range | 0-2 mths | 0-3 mths | 0-1 mth | 0-1 mth |

It is important to understand the broader social factors that may have contributed to the premature deaths of these 11 babies in 2016. Perinatal mortality often reflects the health status and health care of the general population of women, their access to and quality of preconception, reproductive, antenatal and obstetric services, and health care in the neonatal period.⁴²

Domestic violence, maternal education, nutrition, smoking, substance use in pregnancy and poverty are all significant social factors that may have contributed to these premature deaths.

Of the 11 babies⁴³ who died prematurely in 2016, FACS had received reports about all of them before their birth, with concerns about:

- the mother's substance use during pregnancy (six babies)
- the mother experiencing violence during pregnancy (six babies).

⁴⁰ See Red Nose (2017) and NSW Health (2017).

⁴¹ Aboriginal maternal health services are located at Coffs Harbour, Macksville, Port Macquarie and Kempsey.

⁴² See Department of Prime Minister and Cabinet (2014).

⁴³ Numbers do not add to 11 because issues reported to FACS for some babies during the mother's pregnancy included concerns about both problematic substance use and domestic violence.

Substance use in pregnancy

The use of alcohol or other drugs during pregnancy is linked to many potential risks for a baby. While pregnancy increases many women's motivation to change their substance use, it is important to remember that dependence is an illness not just a behaviour.

Some women may not be ready to change. If their pregnancy was unplanned, creating new patterns of behaviour or finding new ways to manage emotional and physical needs can be even more challenging.

However, whether a woman is ready to change or not, her pregnancy is an opportunity. It is often the first time a woman will come into contact with health and child protection services. This gives practitioners the chance to put her in touch with the support she needs, when she is ready. This is a crucial time for readying women for change.

FACS CASEWORK PRACTICE

FACS Casework Practice has a Drug and Alcohol Kit to support practitioners to build greater practice skills in engaging and working with women whose substance use may place an unborn child at risk of harm when born.

Domestic violence in pregnancy

Women are at an increased risk of experiencing domestic violence during pregnancy. If domestic violence already exists, it is likely to become more severe.

While researchers are just starting to see the long-term effects of domestic violence for babies in utero, outcomes like a low birth weight or being born premature have been linked with violence during pregnancy. Women may also be more at risk of postnatal depression, which can impact on the bond and attachment between a mother and her new baby.

Pregnancy and early parenthood are good times for intervention if violence is suspected, as women and children are likely to have regular contact with health professionals. Expecting and new mothers may also be in a good place to be motivated towards positive change.

FACS CASEWORK PRACTICE

FACS Casework Practice has a Domestic Violence Kit to help practitioners to see and understand the varied ways women are hurt by and resist violence and to support women to get help and keep children safe.

2.2.4 Suicide

In 2016, 11 children died as a result of suspected suicide (12 per cent of all deaths of children known to FACS in this period) as shown in Table 5. Six of the children were male and five were female.

Table 5: Children who died by suspected suicide between 2013 and 2016 and were known to FACS

| | 2013 | 2014 | 2015 | 2016 |
|---------------|-----------|-------------|-----------|-----------|
| No. of deaths | 5 | 6 | 4 | 11 |
| % of deaths | 7 | 8 | 5 | 12 |
| Age range | 13-16 yrs | < 13-17 yrs | 13-17 yrs | 13-17 yrs |

All but one of the children who died by suspected suicide experienced trauma in their childhood, including physical abuse, domestic violence and sexual assault.

A number of the children were suffering from mental health problems prior to their death.⁴⁴ Reported concerns were about risk-taking behaviour, such as problematic substance use and self-harm. Several of the children had made a previous suicide attempt or had made threats to end their life.

A review in 2014 of children who died by suicide (or suspected suicide) revealed consistently that these children faced multiple risk factors (individual, social and contextual)⁴⁵ that heightened their vulnerability and compromised their safety. For young people known to FACS, it is often the combination of these factors that poses the greatest risk for suicide.⁴⁶ Risk factors can relate to recent stressful events or triggers; for example, sexual assault, bullying or factors that are likely to increase vulnerability over time, including the cumulative impact of chronic neglect.⁴⁷

Two of the boys who died had been showing signs of sexually harmful behaviour before their deaths. Our reviews found that FACS response did not recognise the children as being in need of care and support and therefore we missed opportunities to understand the risk their behaviour posed to other children and themselves.

FACS CASEWORK PRACTICE

FACS Casework Practice has a Child Sexual Abuse Kit which provides guidance for practitioners in responding to children who have experienced sexual abuse, or who display sexually harmful behaviour.

Two of the children were in OOHC when they died. Supporting vulnerable children in care continues to be a priority for FACS and is an area of child protection practice that requires intensive and skilful casework. A range of initiatives (discussed in Chapter 4) outline the department's commitment to supporting young people at risk.

2.2.5 Motor vehicle accidents

In 2016, nine children died in motor vehicle accidents (10 per cent of all deaths of children known to FACS in this period), as shown in Table 6. This was slightly lower than in 2015. Eight of the nine children who died in motor vehicle accidents were boys.

Table 6: Children who died in a motor vehicle accident between 2013 and 2016 and were known to FACS

| | 2013 | 2014 | 2015 | 2016 |
|---------------|----------|-----------|----------|----------|
| No. of deaths | 6 | 3 | 10 | 9 |
| % of deaths | 8 | 4 | 13 | 10 |
| Age range | 5-15 yrs | 13-17 yrs | 1-17 yrs | 9-17 yrs |

Six of the nine children (67 per cent) died in a car accident while the remaining three children died from a motorcycle accident, a motor scooter accident and a bicycle accident involving a car. Unlike 2015, all of the children who died were nine years of age or older.

Of the children who died in motor vehicle accidents, six (67 per cent) had previously been reported to FACS for risk-taking behaviour. The relationship between risk-taking behaviours and motor vehicle accidents has been a common theme identified by our reviews over a number of years. For practitioners, the growing number of children engaging in transport related risk-taking behaviour highlights the

⁴⁴ This includes a formal diagnosis of mental health issues and concerns about the young person's mental health.

⁴⁵ Individual risk factors include mental health problems, alcohol and substance use, previous suicide attempts and self-harm. Social risk factors include childhood adversity, such as a child protection history; bullying and social exclusion; sexual identity issues; and family factors, such as parental loss, divorce or discord and family depression and suicide history. Contextual risk factors include socioeconomic disadvantage, suicide in family or friends, homelessness and detention or contact with police.

⁴⁶ The suicide of young people was considered in detail in Chapter 3 of the FACS *Child Deaths 2014 Annual Report*, which highlighted a number of themes from reviews to help in understanding the risks associated with suicide.

⁴⁷ See NSW Child Death Review Team (2014).

importance of the continued need for adequate parental supervision and guidance for adolescents. While research suggests that risk-taking behaviour is a normal part of development and moderate amounts can help young people to develop their social competence,⁴⁸ risk-taking behaviours can cause serious harm. When such behaviours are brought to FACS attention there may be an opportunity to work with the child and their family to prevent risk-taking resulting in harm to themselves or others.

2.2.6 Drowning-related deaths

In 2016, five children died from drowning (5 per cent of all deaths of children known to FACS in this period), as shown in Table 7. FACS did not have contact with three of the families prior to the children's deaths. Two children died in hospital after they were found unconscious in a pool at their home and one child died in hospital after being found unconscious in the bathtub.⁴⁹ One child died in a tragic accident when a car he was in rolled into a river. One child died from jumping into water at a dangerous swimming area.

Table 7: Children who died from drowning between 2013 and 2016 and were known to FACS

| | 2013 | 2014 | 2015 | 2016 |
|---------------|---------|----------|---------|----------|
| No. of deaths | 3 | 5 | 1 | 5 |
| % of deaths | 4 | 6 | 1 | 5 |
| Age range | 0-1 yrs | 0-12 yrs | 1-4 yrs | 0-15 yrs |

While deaths from drowning rose in 2016 compared to 2015, the trend in deaths from children known to FACS drowning in swimming pools has continued to decrease. The 2015 Royal Life Saving Society *National drowning report* highlights the significant achievements that have been made in reducing child drowning accidents in Australia.

FACS includes compliance checking for children's access to water in our home inspection checklist, conducted as part of the assessment of FACS foster, relative and kinship care applicants. These requirements have also been extended to NGOs providing OOHC services. Additionally, a number of information resources and fact sheets continue to be distributed to practitioners, foster carers and the public to raise awareness about the requirements around water safety. Despite a decrease in the number of deaths of children from drowning in swimming pools, FACS continues to identify the need to highlight the risks that can lead to children drowning, including:

- safe pool fencing and swimming skills
- restricting access to water⁵⁰
- water awareness⁵¹
- resuscitation⁵²
- active adult supervision⁵³.

Practitioners need to be proactive and curious in their engagement with parents and carers to consider the potential dangers of children accessing water, and the adequacy of safety plans in place for a household. This includes talking to parents and carers about how problems such as substance use, mental health problems and domestic violence may impact on a parent or carer's ability to supervise a child.⁵⁴

48 See Johnson, Sudhinaraset and Blum (2010); see also Kilves (2010).

49 For these three children the drowning was reported to FACS as ROSH.

50 See Royal Life Saving Society – Australia (n.d.).

51 *ibid.*

52 *ibid.*

53 Active supervision means that a child is being constantly watched by an adult who is within arms' reach at all times. See Royal Life Saving Society – Australia (2015).

54 See NSW Child Death Review Team (2015).

FACS Casework Practice provides information for practitioners about water safety.

2.2.7 Inflicted or suspicious injuries

In 2016, four children died of inflicted injuries (4 per cent of all deaths of children known to FACS in this period). Three of these children's injuries were inflicted by a parent.

Two of the children who died from inflicted injuries were girls and two were boys. Three of the children were two years of age or under and one child was under the age of 12 years.

Domestic and family violence were major themes in the child protection histories for three families. Sexual assault by a parent was a significant feature in the histories of two of the families and mental health problems were also a significant theme for two families.

2.2.8 Fire

Two children died in house fires in 2016 (2 per cent of all deaths of children known to FACS in this period). Both fires were suspected to have been started by a child playing with matches or a lighter in the home. One of the homes did not have working fire alarms. No specific reports about inadequate supervision were received prior to the fires, but reports were received about parental drug use, child neglect and domestic violence.

FIRE AND RESCUE NSW

Fire prevention information - Fire and Rescue NSW offers fire prevention and support to families where a child has a fascination with lighting fires. Information on the program is available at fire.nsw.gov.au under 'Fire safety' then 'Educational resources'.

Fire safety awareness - NSW Fire and Rescue also provides a range of resources for households about fire safety awareness at fire.nsw.gov.au under 'Fire safety' then 'Community fire safety'.

Home fire safety checks - NSW fire stations can conduct voluntary home fire safety checks in households where fire risks might be identified as part of a holistic safety and risk assessment. Local fire stations can be found at fire.nsw.gov.au under 'Contact us' then 'Find a fire station'.

2.2.9 Other accidental circumstances

Three per cent of all deaths of children known to FACS in this period were due to accidental circumstances.

One child was bitten by a snake and one child was killed in a tragic accident in a public place. One child died from an accidental drug overdose.

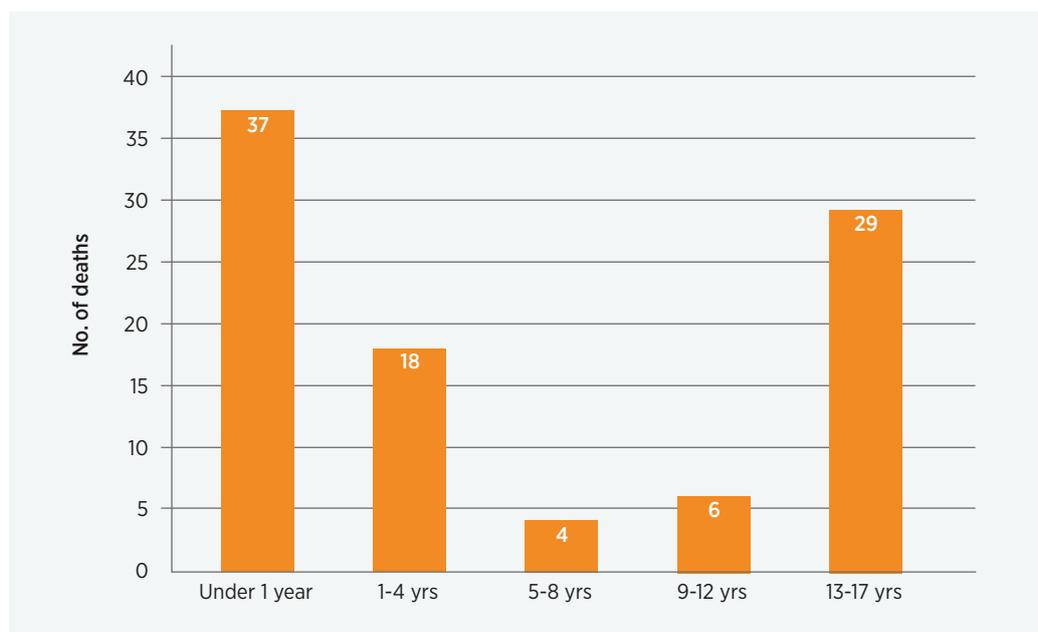
2.3 Characteristics of the children

2.3.1 Age and gender

Consistent with previous years, a large number children known to FACS who died in 2016 were under 12 months old (37 children, or 39 per cent). However, 2016 also saw an increase in the number of deaths of children aged 13 to 17 years, from 15 children in 2015 to 29 children in 2016 (Figure 4). This was largely due to an increase in the number of older children who died from illness and/or disease and by suicide.

Boys continued to be more highly represented than girls across most circumstances of death. In 2016, 55 (58 per cent) of the children who died were male and 39 (42 per cent) were female.

Figure 4: Children who died in 2016 and were known to FACS, by age



Of the 37 babies who died, 29 (78 per cent) died within three months of their birth. The circumstances of the 37 deaths were:

- drowning (1)
- illness or disease (7)
- extreme prematurity (11)
- SUDI (18).

For 24 babies, parental drug and/or alcohol misuse had been reported to FACS before the baby died. For 21 babies, domestic violence had been reported to FACS before the baby died. For 13 babies, parental mental health had been reported to FACS before the baby died.

Of the 94 children who died and were known to FACS, 29 (31 per cent) were teenagers aged 13 to 17 years. This represented an increase in deaths from suicide in 2014 and 2015.⁵⁵ The circumstances of these 29 deaths were:

- drowning (1)
- motor vehicle accidents (8)
- illness and/or disease (9)
- suicide (11).

⁵⁵ Chapter 3 of the Child Deaths 2014 Annual Report highlighted the vulnerability of adolescents and the behaviours that can enhance their vulnerability.

2.3.2 Aboriginal children

In 2016, Aboriginal children continued to represent a proportion of the children who died and were known to FACS. Of the 94 children who died, 26 children (27 per cent) were Aboriginal. This is a decrease from the last two years.⁵⁶

The over-representation of Aboriginal children in child protection systems is well documented. The underlying systemic factors which contribute to this over-representation include the mistreatment of Aboriginal people and the lasting ramifications of previous welfare policies, including the effects of previous separations from family and culture, poverty and perceptions arising from cultural differences in child-rearing practices.⁵⁷

Despite the continued impact that these factors have on Aboriginal communities, there is much that can be achieved with quality child protection practice to limit their impact. Building trust and sharing respect is central to good work with Aboriginal families. The importance of culturally responsive practice with Aboriginal families cannot be overstated. It involves acknowledging the trauma and impact of the Stolen Generations while genuinely valuing Aboriginal culture and connection to community, and working collaboratively within that context to address any safety and risk issues identified for children.

The *NSW FACS Care and Protection Practice Standards*⁵⁸ provide a practical framework to guide and reflect on culturally responsive practice with Aboriginal families and communities. Building cultural connections for Aboriginal children is more than just exposing them to their culture. It is about helping them to have a lived experience of it.

ENGAGING WITH ABORIGINAL CHILDREN AND FAMILIES⁵⁹

- Take the time to understand the multiple and entrenched forms of social disadvantage which have come about because of a history of past practices.
- Work in a way that is culturally responsive and sensitive to the continued impact of the Stolen Generations.
- Use and apply the Aboriginal Consultation Guide and the Aboriginal Child Placement Principles in the *Children and Young Persons (Care and Protection) Act 1998* (NSW).
- Consult often and meaningfully. Engage genuinely in the process and seek specific knowledge, skills and help to make sure casework meets the needs of the family.
- Critically reflect on biases and attitudes to make sure these do not impact on decision-making about a child's safety.
- Support self-determination by actively and genuinely engaging Aboriginal families and kin in conversations and important decisions.
- Find people who are important to the child, make connections and build a network of safety and love around the child.

⁵⁶ In 2015, 31 (39 per cent) of the children who died were Aboriginal and/or Torres Strait Islander. In 2014, 25 (32 per cent) of the children who died were Aboriginal and/or Torres Strait Islander.

⁵⁷ See Human Rights and Equal Opportunity Commission as cited in AIHW (2017).

⁵⁸ See NSW Family and Community Services (2012).

⁵⁹ *ibid.*

2.4 FACS response to the children who died in 2016

This section outlines FACS involvement with the families of the 94 children who died in 2016. Information is provided about the number of reports received, what the reports were about, the decisions made in response to the reports and whether the child was living with their family at the time of their death. This section also considers how FACS responded to families after their child's death to ensure that any siblings were safe.

2.4.1 ROSH reports

Of the 94 children who died in 2016, 74 (79 per cent) were the subject of a ROSH report to FACS in the three years prior to their death.⁶⁰ Forty-five (61 per cent) of those children were reported in the 12 months prior to the child's death. This was slightly more in real terms but less proportionally than in 2015 when 67 (84 per cent) of children were the subject of a ROSH report in the three years prior to their death. Twenty of the 94 children who died in 2016 were not the subject of a ROSH report, but their sibling was prior to the child's death (21 per cent). This was slightly more than in 2015 when 11 siblings were the subject of a ROSH report rather than the child who died.

Most of the children who died (64 or 68 per cent) did not have a lengthy child protection history with between zero and two ROSH reports received prior to their death.⁶¹ Eighteen children (19 per cent) were reported at ROSH between three and five times prior to their death. Twelve children (13 per cent) were reported to FACS on more than five occasions prior to their death.

For the 94 children who died, 19 families were allocated to a caseworker at the time of the child's death, with 16 families having received a face-to-face assessment with a caseworker prior to the death. Of those, eight had received a face-to-face assessment in 2016 and six in 2015. The remaining two families had an assessment prior to 2015.

In addition, for the 94 children who died, 51 families had received a face-to-face assessment from a caseworker prior to the child's death (54 per cent). Of those, 15 had received a face-to-face assessment in 2016 and 17 in 2015.

Regular quality assessments and case plan reviews help to identify the changing needs of children and families, and to adapt plans to meet those changing needs. Establishing realistic goals and agreed case plans to address those goals in consultation with families can create change and lead to improved child safety.

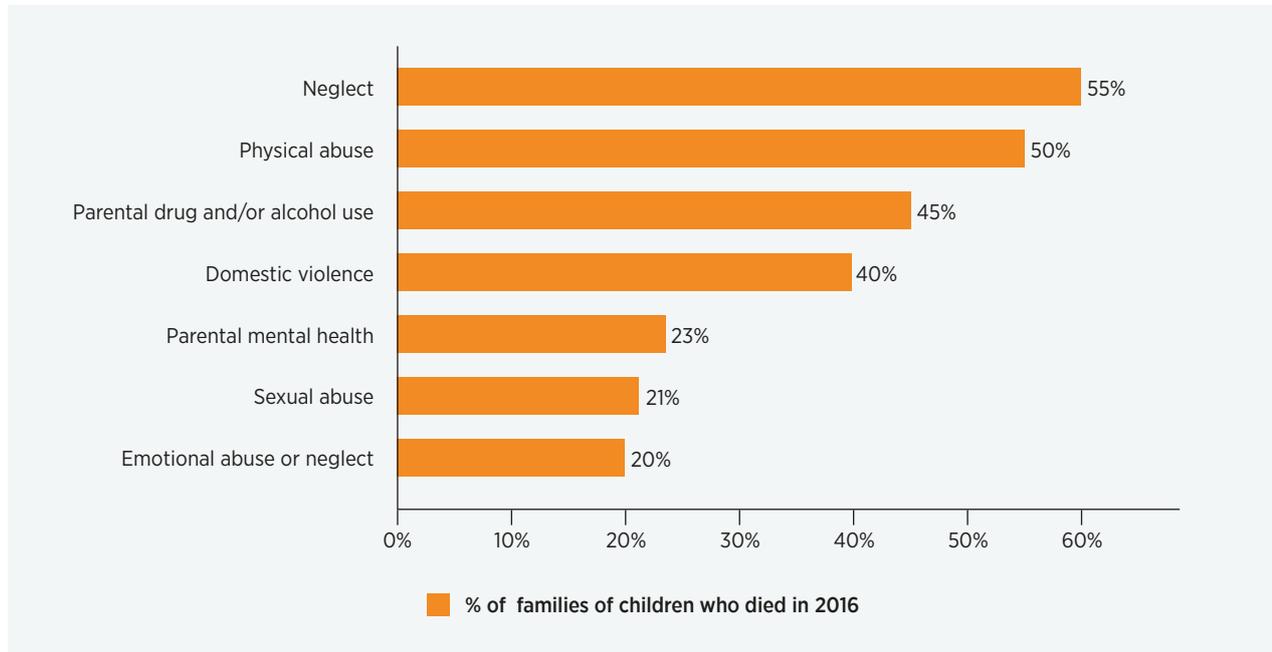
⁶⁰ Prior to 24 January 2010 'risk of harm' (ROH) was the statutory threshold for reporting concerns about a child to FACS. After 24 January 2010, 'risk of significant harm' (ROSH) was introduced as the new statutory threshold for reports. Reports determined to be non-ROSH are not included in this count.

⁶¹ This figure includes children who were not reported to FACS, or those who received one or two reports.

2.4.2 Reported risk concerns

Neglect, physical abuse, and parental alcohol and/or drug misuse were the primary reported issues identified from the ROSH reports received for children who died in 2016 or their siblings.

Figure 5: Children who died in 2016, by selected primary reported issues in ROSH reports received about them and their families⁶²



A total of 52 children and their families were reported to FACS due to ROSH concerns about neglect (55 per cent). These families were reported for one or more types of neglect,⁶³ including:

- physical neglect (24 families)
- supervisory neglect (20 families)
- medical neglect (20 families)
- emotional abuse/neglect (16 families)
- educational neglect (4 families).

IMPROVING OUR RESPONSE TO NEGLECT

Chapter 3 of the *Child Deaths 2015 Annual Report* reviewed all the children who were known to FACS who died from 2010 to 2015 and experienced neglect.

While neglect, physical abuse and alcohol and/or drug misuse were the main concerns reported for children who died in 2016, these rarely occurred in isolation. Many of the families of the children who died had co-existing risk factors present in the reports FACS received about them.

Holistic assessment and family work are essential to understand the child and family's experiences. Working in partnership with families creates opportunities for change that will enhance a child's safety.

⁶² Numbers do not add to 100 per cent as families can be reported multiple times with multiple risk factors.

⁶³ Numbers do not add to 52 as multiple neglect issues can be present in one family.

KEY EXPECTATIONS OF CASEWORKERS FOR HOLISTIC WORK WITH FAMILIES ⁶⁴

- Seek to understand children’s experiences outside of one event.
- Observe the child in their home interacting with their siblings and parents.
- Work proactively with families.
- Consider the family in context when completing assessments and ongoing work. For example, culture, trauma history, disadvantage, family history and composition.
- Examine all information and think through all possibilities about what has happened and why.
- Establish clear goals with the child and family and agree a realistic case plan to reach those goals.
- Engage the family to identify what needs to change and why that leads to improved safety.
- Review the case plan regularly to meet the changing needs of the child.

2.4.3 Children in out-of-home care

In 2016, 10 children were in OOHC when they died, as shown in Table 8.⁶⁵ This is 11 per cent of all deaths of children known to FACS in this period.

Table 8: Children who were living in out-of-home care when they died between 2013 and 2016

| | 2013 | 2014 | 2015 | 2016 |
|---|----------|----------|----------|----------|
| No. of deaths | 6 | 10 | 9 | 10 |
| Placed with a relative | 3 | 2 | 1 | 4 |
| Placed with authorised carers | 3 | 7 | 7 | 4 |
| Other (e.g. independent living, residential care, hospital) | 0 | 1 | 1 | 2 |
| Other data | | | | |
| % of deaths | 8 | 12 | 11 | 11 |
| Age range | 0-15 yrs | 0-15 yrs | 0-17 yrs | 1-17 yrs |
| Aboriginal and/or Torres Strait Islander | 1 | 1 | 6 | 0 |
| Parental responsibility of Minister (any aspect) | 4 | 9 | 9 | 8 |

Of the 10 children in 2016 who died while living in OOHC:

- four were placed with family
- two were living independently
- four were living with authorised carers.

The circumstances of death for these 10 children included illness and/or disease, suicide, drug overdose and drowning.

Two children were in the parental responsibility of their relative and eight children were in the parental responsibility of the Minister for Family and Community Services. Of those eight children, two children were placed with extended family, two children were living independently and four children were living with authorised non-government carers.

⁶⁴ See NSW Family and Community Services (2012).

⁶⁵ As at 30 June 2015, there were 17,585 children and young people in OOHC. This is a decrease of 7 per cent on the previous year. The reduction is largely due to the implementation of guardianship orders on 29 October 2014 – this change enabled relative and kinship carers who had full parental responsibility for a child or young person in their care to become their guardians. Children on guardianship orders are no longer considered to be in OOHC. See NSW Family and Community Services (2016a).

It is important to consider that authorised carers provide care for some of the most vulnerable children in the state, some of whom have experienced significant trauma and abuse, or who were born in extremely vulnerable circumstances. Carers need to be equipped with sufficient knowledge, skills and ongoing support to respond effectively and empathically to children's needs. It is crucial that carers are able to provide children with safe and nurturing environments; provide the opportunity for healthy attachments to occur; and support children's ongoing cultural, health and educational needs in care. Equally important is the need for carers to be able to access appropriate support networks, including practitioners, to work in partnership so that children in OOHC have every opportunity to reach their potential.

As more children are being cared for in NGO placements, NGOs need to have robust arrangements in place to manage critical incidents, mitigate the risk of incidents occurring and guide responses to critical incidents to ensure the best outcomes for children. FACS has developed a number of resources to help NGOs manage critical incidents in OOHC and we continue to provide support to and collaborate with the NGO sector to build capacity in this area.⁶⁶

2.4.4 How FACS responded after the child death

When a child dies due to abuse, neglect or in suspicious circumstances, or the child is in OOHC, FACS has the responsibility to assess the safety of other children living in the same household, including unborn children.

The purpose of the assessment is to identify immediate safety or risk issues for the siblings of the child who died, and to ensure that the family is linked to appropriate supports and counselling. It requires skilful and compassionate practice that is mindful of significant grief and loss being experienced by the family as well as acknowledging any current risks identified.

Of the 94 families of children who died in 2016 and were known to FACS, 35 (37 per cent) received an assessment by FACS following the child's death which involved:

- FACS providing ongoing case management to the family (12 children, 34 per cent)
- the families being referred to other services and FACS ending its involvement (12 children, 34 per cent)
- the siblings being taken into care (5 children, 14 per cent)
- other responses such as FACS ending its involvement because no risks were identified (6 children, 17 per cent).

The remaining 59 families (63 per cent) did not receive an assessment by FACS following the child's death. Of these families, a decision was made that no response was required due to no risk issues identified for the surviving siblings (30 children)⁶⁷ or no young people living in the same household who were under 18 years (15 young people)⁶⁸. The remaining 14 families did not receive an assessment for a range of other reasons including that the child's death was screened by the Helpline as non-ROSH and no further action was taken or the family was already allocated to a caseworker. The number and proportion of families who received a sibling safety assessment by FACS in 2016 was similar to 2015.

The next chapter (Chapter 3) focuses specifically on how FACS responds to a child's death, and the process of sibling safety assessments.

⁶⁶ See NSW Family and Community Services (2016b).

⁶⁷ The CSC is not required to complete an assessment if the death is clearly attributable to natural causes or an accident where there is an absence of suspicious circumstances involving the parents, carers or any person in whose care the parent left the child who died. See Department of Human Services (2010). The majority of the children whose families did not receive an assessment by FACS following the child's death died of an illness and/or disease (13 children). Other circumstances included where the child died while interstate (one child), in a motor vehicle accident (six children), by suicide (three children) and by accidental asphyxia (one child).

⁶⁸ This includes where the child who died did not have any siblings or the child had siblings who were in OOHC at the time of the child's death.

Chapter 3: Responding to a child death

The death of a child is profoundly distressing for parents and other family members. Whether the death is anticipated for medical reasons, unexpected and sudden, or caused by the intentional act of another, it can create intense emotional responses for families and the professionals involved.

When a child dies it can be complicated for families with children who have been previously reported at ROSH. Such families may be more likely to be disadvantaged and present with a range of vulnerabilities such as unemployment, homelessness, mental health issues and problematic substance use.

While understanding and respecting grief, it is critical that the safety of children who live in the same home as a child who has died is assessed holistically by FACS practitioners.

This chapter is presented in three parts. The first outlines the key role child protection agencies (such as FACS) play alongside police, ambulance and health professionals whenever a child dies. The second part describes the impact of a child death on families from our review of the literature, in terms of personal responses to grief and loss, and on existing vulnerabilities. It also describes the impact on child protection practitioners. The final part highlights the key areas of practice involved in completing holistic sibling safety assessments with vulnerable families.

To inform this chapter, the SCR considered FACS responses to families following the death of a child⁶⁹ during 2015 and 2016. SCR examined the circumstances of each child's death, the outcome of the sibling safety assessment and other work undertaken in response to the death. SCR also spoke with FACS practitioners who had completed sibling safety assessments to hear directly about practice challenges, to identify key practice themes and to understand what works well when engaging with families.

3.1 Understanding the role of key agencies in child death investigations

In NSW a number of government agencies have key roles in responding to child deaths. Police provide an investigative response; ambulance officers, paramedics, doctors and nurses treat and attempt to sustain life; and allied health and social workers provide support to grieving families. In some cases, child protection practitioners work with families to assess the safety of other children in the home, and work to reduce any risks that are identified.

Police, doctors, health care professionals and emergency workers are required by law to report certain deaths, called 'reportable deaths'⁷⁰, to the NSW Coroner. These reportable deaths include:

- children who were in OOHC
- children who have been reported to be at ROSH to FACS within three years of their death
- siblings of children who have been reported to FACS within three years of the death
- deaths which might be due to abuse, neglect or which are otherwise suspicious.

When the cause of a child's death is unclear and police, emergency services or health professionals have significant concerns for the safety of other children living in the home, those services are also required to report their concerns to FACS.

⁶⁹ The children in this cohort were children who were 'known to FACS' either as a child, or a sibling of a child, who had been reported to FACS within three years of the child's death, or a child's death that was reported to FACS because the deceased child's siblings were considered to be at risk of significant harm (ROSH) (due to the suspicious nature of the death).

⁷⁰ Under the *Coroners Act 2009* the definition of reportable deaths is quite broad, so for the purposes of this report the definition provided is limited to s24 of the Act.

PRIMARY REPORTERS

During 2015 and 2016 police, ambulance or hospital emergency departments⁷¹ were the primary reporters of recent⁷² child deaths to the child protection Helpline, collectively reporting 48 child deaths that had occurred either on the day of the report or in the proceeding day.

The following sections provide an overview of the role each key agency plays when responding to reportable child death.

3.1.1 Police

Police has primary responsibility for investigating the circumstances of child deaths in NSW.⁷³ It is the responsibility of the police Local Area Command (LAC) that covers the address where the child died to complete the initial investigation, unless the expertise of more specialised police, such as the Homicide Squad or the Child Abuse Squad (CAS),⁷⁴ is required.

Initial police investigations will involve gathering evidence from the home or location the child was found, interviewing family members and other witnesses and forming an initial view about whether the death is suspicious.

Police are required to formally advise the NSW Coroner of all reportable deaths using Form P79A *Report of Death to the Coroner*. Form P79A provides a summary of the known details of the deceased person, their family members and what is known about the circumstances of the death. It will also outline for the benefit of the Coroner the preliminary views of police as to whether the circumstances of the death are suspicious.

Police officers have a key role in linking family members affected by a child death with key support services available through the Department of Forensic Medicine (see below).

3.1.2 Ambulance and health

Along with police, ambulance officers and paramedics are most often the first to arrive at a home after a child death has been reported. The key roles of ambulance officers and paramedics are to perform medical procedures to sustain life, stabilise patients and provide pre-hospital care while transporting patients to the hospital for ongoing medical care.

When children arrive at hospital and are unable to be resuscitated, medical staff and social workers provide comfort and support to grieving parents and family members. If the death is considered a reportable child death, the following protocols must be followed:

- A certificate as to the cause of death cannot be issued by the senior medical officer.
- The hospital must notify police of all reportable child deaths (if the child's death was not already known to police).
- The child's body should not be disturbed and all medical equipment⁷⁵ used to treat the child needs to remain in place when the child is transported to the Coroner.
- The child's body should not be washed.

⁷¹ In many cases multiple reports were received about the same child death. Often separate reports are made to the Child Protection Helpline by police and emergency services who responded to the emergency call, and also by hospital social workers, nurses or doctors who treated the child or had a role with the child's family. The 48 reports quoted here reflect the number of children who died, and only counted the first agency to report the child's death.

⁷² As indicated earlier in the report, most child deaths in NSW are from illness and/or disease and do not require a child protection response. As part of collaborative work with FACS, the NSW Ombudsman regularly provides advice on all child deaths (of children who were 'known to FACS') that are reported to its Child Death Review Team by the Office of Births Deaths and Marriages. In 2015 and 2016 this accounted for around 80 (46 per cent) of all child deaths reported to FACS.

⁷³ See NSW Police (2016).

⁷⁴ CAS detectives are specially trained to investigate crimes against children, including sexual assault, physical abuse and serious cases of neglect. CAS works in partnership with FACS and NSW Health with specialised tri-agency teams based at metropolitan and regional locations throughout NSW.

⁷⁵ Including drip lines, cannulas, needles, endotracheal tubing, feed bags and so on.

When a reportable child death is identified, a senior hospital officer is required to talk with parents and other relatives about the formalities required by the Coroner's Act; specifically that (while the child's body remains at the hospital):

- access to the child's body for identification purposes needs to be authorised and supervised by police
- access to the child's body for any other reason, including compassionate reasons, will need to be supervised by a nurse unit manager or social worker
- where the death is considered suspicious or criminal charges are being considered, police are required to authorise and supervise any access to the child's body
- all relevant medical records about the treatment of the deceased child are provided to the Coroner.

3.1.3 Coronial services

The NSW Coroner investigates reportable child deaths to determine the identity of the deceased and the date, place, circumstances and medical cause of death.

Where possible the Coroner will attempt to make a determination about the cause of death using the least intrusive examination possible, such as an external examination, CT scan⁷⁶ or blood and tissue toxicology testing. When the cause of death cannot be established by these methods, or the death is considered suspicious, other more invasive examinations will be requested. This may involve the coroner ordering a post-mortem (autopsy) or more detailed forensic examination and toxicology reports on body tissues.

POST-MORTEM EXAMINATIONS

During a post-mortem all parts of the body undergo a detailed inspection to determine the presence, nature and extent of any disease or damage. This inspection involves all organs being removed from the body and examined. Small samples of tissue are taken from individual organs and are usually retained forever to ensure that any questions which may arise months or years after death can be answered by further examination, perhaps by new techniques which were not available at the time of the initial post-mortem examination.

In some cases, whole organs may have to be retained for an extended period to detect finer details of disease or damage. This is especially true of parts of the nervous system such as the brain. Organ retention tends to occur when the initial post-mortem examination does not provide adequate information or where the cause of death can only be verified following further microscopic examination. This pathology can take a number of weeks to complete.⁷⁷

Where there is a suspicion about the cause of death, the Deputy State Coroner has the power to hold an inquest, in which witnesses⁷⁸ can be called and evidence is submitted to assist the Coroner determine the date, place, circumstances and cause of the child's death. When a child death remains an active criminal investigation the Coroner may suspend any further involvement with the matter until the criminal investigation has concluded.

Coronial investigations can be complex and protracted. They often involve the collection and assessment of forensic evidence to assist the Coroner's determination. While some matters can be resolved quickly, others may not be finalised for 12 months or more.

At the conclusion of an inquest the Coroner can make recommendations to government about improving public health and safety.

⁷⁶ CT stands for 'computerised tomography'. CT scans are sometimes called CAT scans. See NSW Health (n.d.).

⁷⁷ See NSW Department of Justice (2016).

⁷⁸ Professionals who had prior involvement with the child; expert witnesses, such as forensic pathologists; or family members and other witnesses to the child's death.

If at any time during the course of an inquest or inquiry the Coroner forms a view that a known person has committed an indictable offence in connection with the death, the inquest will be suspended and the matter referred to the Office of the Director of Public Prosecutions, for its consideration of possible criminal charges.

NSW CORONER

More detailed information about the NSW Coroner and its support services can be found at coroners.justice.nsw.gov.au

SUPPORTS FOR FAMILIES AFFECTED BY A CHILD DEATH

The Coroner's Court, through its **Coronial Information and Support Program**,⁷⁹ offers a range of support services, including:

- advice and support for families who may wish to view the deceased's body or want to understand their rights to exercise certain cultural practices around death
- free short-term counselling
- referral to other agencies for ongoing support
- support for individuals and families exposed to deaths occurring in traumatic circumstances
- help with understanding the role of the coroner and the court's processes.

Some of these services are provided by the Coroner's Court, while others may be provided by partner agencies and specialist social service providers in regional areas of NSW.

Contact the **Coronial Information and Support Program** on (02) 8584 7800 (Sydney) or (02) 4922 3700 (Newcastle).

3.1.4 Family and Community Services

The key role of a child protection practitioner, when responding to a report following a child death, is to assess the safety and wellbeing of the other children living in the same household. It is not the role of practitioners to investigate the cause of the child's death; however, the information gathered about the death can be used to inform the assessment of safety and risk. At the same time the practitioner will work alongside the family to assess the family's support needs, before making a decision about whether to remain involved with the family.

Sibling safety assessment outcomes

Sibling safety assessment data from 2015 and 2016 showed that of the 173 children who died during that period, a sibling safety assessment was completed for 63 families (36 per cent). For just under half of the families (31 families, 49 per cent) FACS continued to work with them for a period of time to reduce the identified risks and increase safety within the family. For 22 families (35 per cent) FACS either referred the family to support services or did not intervene because no safety concerns were identified for the children. In 11 (16 per cent) of families, children were taken from their parents and placed in alternative care because there was an absence of safety within their immediate family.

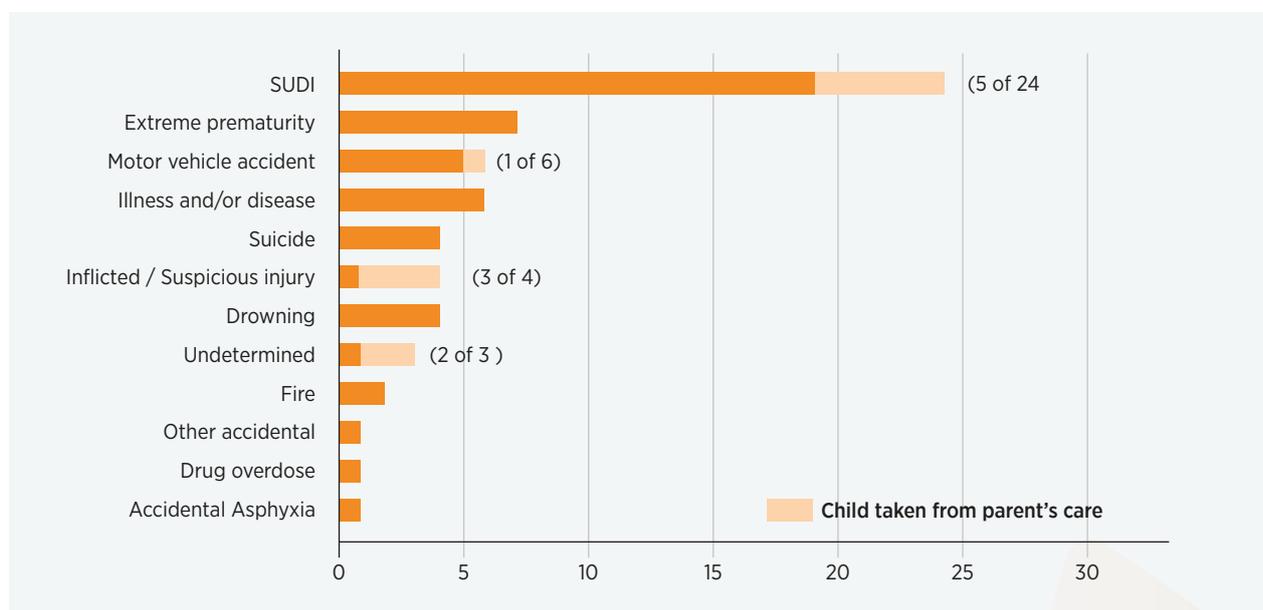
The process of child protection assessment, in the context of a child death, is further described at Section 3.3. In summary, an assessment involves reviewing information already known by FACS about the family alongside any newly reported concerns, and talking with police or emergency services who

⁷⁹ See NSW Attorney General & Justice (2016).

attended the home to get a better understanding of the seriousness of the child protection concerns identified. Practitioners will speak with other services that may already be involved with the family to better understand any existing vulnerabilities, before visiting the family at home. This will include police to confirm the status of any investigation into the child's death and the impact it may have on the safety assessment. When visiting the family, practitioners will talk with the parents or carers, with other family and community members and, importantly, with the siblings of the child who died (if they are of an appropriate age).

Of the 63 sibling safety assessments completed it was found that practitioners took more protective action, such as taking children from the care of their parents, when there was greater uncertainty about the cause of a child death (see Figure 6). For example, most of the siblings of children who died from injuries believed to have been inflicted by another person, that were suspicious or where the cause of the injuries were unable to be determined, were taken from their parents' care. Of the 24 children who died in SUDI related circumstances, five children (21 per cent) were taken from their parents, following safety and risk assessments. This was often due to unsafe homes, serious and persistent drug and alcohol use, or an uncertainty about which carer may have been responsible for the child's death.

Figure 6: Sibling safety assessments in 2015 and 2016 by cause of death and child taken from parents' care.



Sibling safety assessments were not completed with 110 families (64 per cent). For most families (67 of 110 families, 61 per cent), the decision not to do an assessment was made because there were no risks identified in the report about the child's death made to FACS. For another 38 families (35 per cent), FACS was advised there were no other children living in the home at the time of the child's death.

3.2 Understanding the impact of child deaths

Good sibling safety assessments are demonstrated by practitioners genuinely understanding a family's experiences and forming relationships that give dignity, show empathy and build trust.

This section explores how casework teams can best prepare themselves for this work by:

- understanding how a family might experience the death of a child
- reflecting and understanding how practitioners might respond to this difficult work.

3.2.1 A family's experience when a child dies

Understanding a family's experience of grief and loss is critical to quality practice. While a FACS child protection practitioner's role is not to provide therapy or counselling, there are many ways in which understanding a family's experience can support good practice after the loss of a child.

Understanding grief and loss

Grief is an intense sorrow following the death of someone who was loved and valued.⁸⁰ Grief can present itself in different ways. Many people show their grief physically through crying, not sleeping or not eating. A person in grief might experience feelings of shock, disbelief, anger, guilt or sadness, as well as relief, hope and acceptance.⁸¹

These painful, intense and sometimes conflicting feelings are likely to change a person's life permanently. Parents need the time and support to absorb their feelings of loss and adapt to the changes this loss may bring. While these feelings can't be stopped by quick fixes or simple solutions,⁸² they are more likely to decrease over time with support, connection and healing.

AVOIDING ASSUMPTIONS ABOUT GRIEF AND LOSS

Everyone's experience of grief is unique. It's important to avoid assumptions about what a parent's grief should look like, or to use pathologising language that labels a parent. For example:

- Is a parent 'depressed' or deeply sad about their loss?⁸³
- Is a parent being 'difficult to engage', 'hostile' or 'resistant', or are they just struggling to deal with their intense feelings of anger, pain and disbelief about their child's death?

Supporting families through vulnerable times

In addition to managing the complex and overwhelming feelings of grief and loss following a child's death, families may face other challenges and barriers, including:

- feelings of blame
- experiences of stigma and isolation from the community, especially if the child's death was due to suicide, violence or was sudden and unexpected
- the compounding effects of any previous experiences of violence or abuse⁸⁴
- the need to navigate a complex system of police investigations, child protection assessments, ambulance and health services and the new involvement of supports such as crisis or grief and loss services.

These challenges can create profound vulnerabilities for some families, which may in turn raise safety and risk concerns for children. Research consistently shows that parents who have lost a child are at increased risk of developing physical and mental health problems or turning to drugs or alcohol to manage their intense pain.⁸⁵

⁸⁰ See *beyondblue* (2016).

⁸¹ See McKissock et al (2012).

⁸² *ibid.*

⁸³ See IWG (2013).

⁸⁴ See Escobar-Chew et al. (2015).

⁸⁵ See Denhup (2017), Youngblut et al. (2013) and Harper et al. (2014).

Supporting families to support children

Children experience grief and loss with the same intensity as adults.⁸⁶ They may show some or all of the common reactions to a sibling's death, such as regret, guilt or anger. Practitioners can play a role in supporting families to help children learn to live with their grief, get support from others and stay connected to life.

WHAT CHILDREN NEED AFTER THE DEATH OF A SIBLING

Truth

Children need to know their questions will be answered. Talk to parents about how they plan to answer any difficult questions from a child. If a parent is worried or struggling, offer to practise these conversations with them so they feel well prepared.

Connection

Children need the space to explore, normalise and validate their feelings with a trusted adult. Help the child understand who they can talk to and include adults who are not dealing with their own feelings of grief and loss after the child's death. This could be extended family, a close family friend or professionals like teachers, counsellors or the FACS child protection practitioner.

3.2.2 A practitioner's response to a child's death

'No matter how prepared I felt, visiting a family at a time of such deep sorrow, and only hours after their youngest baby had died, was one of the toughest jobs I have ever done.'

FACS caseworker.

Practitioners who are required to visit a family after a child has died can feel understandably worried about how their intervention will be experienced by the family. They may feel challenged about how they can assess safety and risk and have difficult conversations with a grieving family. Practitioners may be concerned that their intervention will make a family's grief worse.

These worries are important to address before the first visit to the family. Without opportunity for planning and critical reflection, practitioners may be unclear about the purpose of their visit or their role with the family. This uncertainty can also affect families, who may be more likely to be upset, worried, distressed or distrustful if they are not clear about why the practitioner is in their home.

Some practitioners may not see risk or safety issues for children in the family because they are too focused on supporting a parent's grief. The dual role of assessing safety and risk, and providing support to families, can feel incompatible – even for the most skilled of practitioners.

Section 3.3 explores how casework teams can plan for a visit to a family after a child has died. There are also opportunities for practitioners to critically reflect on their own approach to the work by considering the reflective prompts below.

3.3 Assessing safety after a child death

To support FACS response to child deaths that are reported to the Helpline, FACS has a practice mandate⁸⁷ about sibling safety that requires a child protection practitioner to visit the family of a child who has died within 24 to 72 hours if the circumstances of the death is considered 'suspicious' or 'caused by abuse or neglect'. The purpose of the visit is to assess the safety of other children in the home and to offer supports to the family if needed.

⁸⁶ See National Centre for Childhood Grief (2017b).

⁸⁷ See the FACS Casework Practice intranet documents section of the reference list.

3.3.1 Preparing to visit the family

Understanding your role and the purpose of the visit

Research shows that practice leadership is critical in supporting practitioners prepare for a sibling safety assessment⁸⁸ and it can help improve the quality of practice with vulnerable families. Before visiting a family, practitioners and managers can practise having difficult conversations, plan for the safety and risk assessment and talk about what practical supports might be available for the family. The questions below provide discussion prompts for managers and practitioners when preparing for a sibling safety assessment with a family.

PREPARING FOR A SIBLING SAFETY ASSESSMENT

Important questions to ask before visiting a family that has lost a child:

- How am I feeling about this visit? Am I worried, nervous or afraid?
- Do I understand my role in visiting the family? If not, how can I be clearer about this – with myself and the family?
- Am I holding any biases or assumptions about the challenges this family has experienced in the past? About the way the child died? How can I reflect on this during and after my visit to make sure it does not affect my decision-making?
- What are my expectations about how the parents and siblings will be experiencing their grief? How can I keep my thinking open to different perspectives and experiences of grief?
- How can I draw a careful balance between showing empathy and support to the parents while staying focused on the safety and needs of the children?
- Am I feeling upset or distressed about what I know about this child's death? If so, how can I seek help or support from my colleagues, manager or employee support services?⁸⁹

Considering history

'Get the whole picture before you knock on the door'

FACS caseworker.

When preparing for a sibling safety assessment, it's important to understand the child protection history of the family, including information received in the previous 12 months. This enables child protection practitioners to have a good understanding of the family's existing vulnerabilities, concerns reported previously and FACS responses, before the visit. It also provides an opportunity for practitioners to plan what questions to ask parents and predict what level of assessment is needed. Given what we know about the impact of a child death on parents and children, understanding the family's history is important to assess if their emotional responses to the death may heighten underlying vulnerabilities.

Talking with services already involved

'It's important to know about the role of other agencies, their interaction with family and their timeframes and coordinate with them.'

FACS caseworker.

⁸⁸ See Reimer (2013).

⁸⁹ In NSW, FACS provides support to caseworkers through the Employee Assistance Program.

Collaborating with other services is an essential part of the preparation for responding when a child has died, particularly when the death is suspicious or when other agencies such as NSW Police or Health are investigating the death for criminal or other purposes. The timing of a visit to see parents may need to be negotiated. If a parent has been taken into custody, special arrangements might need to be negotiated with police to meet with the parent in jail. If siblings are in hospital, the hospital may be able to help with arranging support for the family and with somewhere to meet the family.

'The hospital social worker and Aboriginal liaison officer were very helpful, organising rooms so that we could talk to the family privately.'

FACS caseworker.

Other emergency services can also provide useful information about their contact with a family in the immediate hours after a child's death. This can help to avoid situations where parents and children need to tell their stories repeatedly, causing unnecessary further distress. The information about conversations other services have had with parents can also be useful to inform the safety and risk assessment.

'Talking to the police directly was helpful, and gave me a good insight into what happened.'

FACS caseworker.

When a child dies in OOHC and a sibling safety assessment is needed, the child protection response needs to be coordinated with any other services involved with the family, including NGOs that hold case management responsibility for the child or their siblings.

The prompts below provide guidance about the types of questions a child protection practitioner might have of the other services involved immediately after a child has died, to inform the assessment of safety and risk.

TALKING TO OTHER SERVICES

Police

Do the police have any concerns that the child died in suspicious circumstances? What are the police suspicions and do they raise any safety concerns for surviving children in the home?

Health

Does health have any suspicions that the child's death was a result of non-accidental injuries? Does this raise any safety concerns for other children in the home that might need to be considered in the safety and risk assessment?

NGOs

If the child was in OOHC, were any circumstances of the death unknown or suspicious? What is the NGO process for investigating allegations of child abuse against carers when a child is in OOHC? Does FACS response need to be coordinated with the NGO? Are any other children living in the home of the foster carer (including the carers' birth children?) Is the NGO clear about FACS role to assess the safety of other children in the home?

NSW Fire and Rescue

Is NSW Fire and Rescue investigating any suspicious circumstances from a house fire? If so, what are the suspicious circumstances? For example, were the parents at home when the fire was started? Was the fire started by a child playing with matches or a lighter? Is the child who lit the fire one of the other siblings and are there any safety concerns for the child?

Thinking through the impact of the death on all family members

The impact of a child's death on a family was discussed earlier. As part of the preparation for a sibling safety assessment it's important to understand that the child's death will affect each family member differently. When considering the impact on all family members, practitioners still need to stay child focused. Parental grief may be more visible and can sometimes distract attention from the needs of the children in the family.

TALKING WITH CHILDREN

In partnership with the parents, talk with each child about their experiences of their brother's or sister's death. What type of relationship did they have with the child who died? Did they look after their brother or sister, or did their brother or sister care for them? Be curious about how this links to the child's current and future experiences of grief. Talk to the family about planning together to support each child in the family.

There are a number of useful resources that provide insight into children's experiences of grief and loss. Appendix 2 provides an overview of children's understanding of death and common grief reactions.

Engaging with families at a time of great distress

'I wasn't prepared for the difficulty of sitting with someone in extreme and current grief.'

FACS caseworker.

The quality of the relationship between practitioner and family has been described as 'the single most important condition to achieving change'.⁹⁰

The development and maintenance of effective relationships is difficult work, particularly in statutory child protection. It requires great skill and self-awareness to create relationships in the context of crisis and involuntary service provision, particularly with parents who are vulnerable and have lost a child, and may see the practitioner as a threat.

The following section provides practice advice about how to approach a family after a child death in the context of visiting the family to talk about the safety of the surviving siblings in the home.

Expressing sorrow and condolences

'I said 'I'm really sorry about the loss of Julie'. It was important to name her, and put it out there, and be clear about the purpose and process with the parents and support workers. Clarity and honesty were essential.'

FACS caseworker.

It's important to show empathy to a parent after the death of a child regardless of the circumstances in which the child died. The key message for expressing sorrow and condolences needs to be genuine and non-judgemental.

I am so sorry for your loss, and that we have to meet at such a difficult time.

⁹⁰ See Ashley and Nixon (2007).

If you have an existing relationship with the family, you could mention something positive that you recall about the child.

David was such a smart and funny little boy.

Offering a support person to be with the parent while you speak with them may lessen anxiety for the parent.

Is there anyone we can call to be with you and support you while we speak with you today?

Raising the issues of concern

Parents need child protection practitioners to be clear with them about the purpose of the visit after a child has died. The examples below provide some ideas about raising different concerns directly with parents.

We're here today because we're worried about how you're managing after Mary's death, and to understand how things have been for you and also for Mary's brother David. In the past, you've worked hard to stay sober. I'm worried that Mary's death might make you feel like drinking again and this might make it hard for you to look after David. Can we spend some time talking about what supports you have in place over the next few days and if there are any additional supports you might need.

I know that when the police visited last night after Jim had hit you, he was still very angry and was yelling at you, blaming you for Josh's death. That must have been awful for you and for the children. I want to spend a little time talking with you about what happened before the police arrived and what happened after they left. With your help I'd like to understand more about how you responded to Jim's anger, and your and the children's safety over the next few weeks.

I understand that you've struggled with depression before. I'd like to spend a little time understanding what it's been like for you since Jack's death, who you have to support you and the children, and if there's anything you might need.

Identifying key family and kinship supports (safe allies)

'Mum and dad had lots of family around. We talked to the big family group, mum, grandma, aunties and uncles. We also met separately with the two groups, mum's family and dad's family.'

FACS caseworker.

The immediate period following a child death often brings a lot of family and community members together to mourn the loss of a child and it can provide an opportunity for practitioners to identify potential networks of safety among extended family and community members. Safe connections to family and enduring relationships build long-term resilience for children, especially those who have experienced the loss of a sibling.

Without such connections, children can be left vulnerable to experiencing isolation and loneliness, again particularly for those who have lost a sibling. Children need confident reassurance from a trusted adult who can make them feel safe and secure. If a child's parent is not able to provide this, because of their own grief, it's important that another safe, familiar person is able to take on this role, until the parent can do it themselves. A grandparent, relative or close friend may need to fill this role for a time, without taking over the role of parents, or making them feel inadequate.

When visiting a family to complete a sibling safety assessment, practitioners need to be alert to family and community members who are also visiting the family, to try to identify a circle of safe and supportive adults who can help the family in their time of grief.

Identifying other existing supports

Some families may already be involved with other services that can offer support after a child has died. These services can also provide child protection practitioners with information about a family's strengths and needs. Early intervention services, family support services, child care centres and schools should be contacted when a child has died to talk about their recent contact with the family and to find out how they can support the family in the future.

CULTURALLY RESPONSIVE PRACTICE

A family's response to death may be influenced by practices, customs and traditions connected to culture, religion and beliefs⁹¹. The following questions can be considered when working with Aboriginal families or families from culturally linguistically diverse background and are best explored with the help of a FACS multicultural or Aboriginal caseworker.

- Who should be present just before and after the death of a child in palliative care and what ceremonies are performed around the child's death?
- How is the child's body handled after their death, including cleansing and dressing, who is permitted to handle the child's body, and will the child's body be buried or cremated?
- How does the family express their grief – quietly and privately or loudly and publicly?
- What rituals are performed and who is included (brothers, sisters, extended family, community members or friends)?
- Is there a mourning period and if so, how long is it? How will family members dress and behave during the mourning period?
- How is the child who died honoured in the family and are there any ongoing rituals to celebrate or connect with the child who died?
- Will family members be expected to take on new roles? For example, will brothers or sisters of the child who died need to take on new caring roles for younger children in the family?

⁹¹ See Australian Multicultural Foundation Aged Care Training Institute (MACTI) (2002).

3.3.2 Assessing safety and risk and planning for safety

'It's not about finding out the cause of death for the child, it's about assessing the safety of the siblings; it's up to the Coroner to assess death.'

FACS caseworker.

Avoiding the 'crisis' response

It's common for people to focus on culpability or blame after a child has died, especially if the circumstances of death are unknown or suspicious. Questions might be asked about the work of each service involved with the family before the child died; such question might focus on who caused the child's death and whether there is a need to act decisively to protect other children.

While these types of questions are important, the real focus needs to be on safety and risk (the sibling safety assessment). The sibling safety assessment should consider the questions below.

SIBLING SAFETY ASSESSMENT QUESTIONS

- Do the circumstances surrounding the child's death raise any concerns about safety and risk for other children living in the home? Do police or health services have any concerns?
- What is the recent child protection history of the family? Do the parents have any known vulnerabilities that might be exacerbated by the death of their child? (e.g. problematic substance use or mental health issues.) What are the parents' views about this? Do they have support? Do they need or want support?
- How old are the surviving children and what are their responses to the death of their brother or sister? Do they have support? Do they need or want support?
- Does the family have extended family and community members supporting them? Who are they and what role are they playing to support the family? How long can they provide support?
- Are any other services involved with the family? What support is it providing and how long will the support be provided?

Safety planning: what does tonight, tomorrow, next week look like?

Working with a family in the context of a child death and family grief is complex.

Child protection practitioners need to acknowledge the risks to children in the family, and balance known risks with the family's strengths and resources. Some children will need to be taken into care straight away after their sibling has died because they are unsafe at home. But it is the responsibility of child protection practitioners to work as a team with the child, parents, carers and inter-agency partners to create safety and make the best decisions and plans possible to avoid separating a child from their family.

To end this chapter about FACS responses to families following the death of a child, Alyssa's story shows the importance of collaboration and safety planning with families.

Alyssa's story

A report was made to FACS about Alyssa just after her birth because of worries following the death of her older brother, Jack, one year earlier. There were suspicions that Jack had been shaken, although this was never confirmed by medical experts.

After Alyssa's birth, child protection practitioners faced a long and complex process in trying to work out whether she was safe at home. It would have been easy to take the 'safest' option and remove Alyssa from her parents' care. Such a decision would have immediately removed one set of risks, yet brought with it another set – Alyssa not being cared for by her parents and finding a secure long-term placement outside of Alyssa's immediate family.

Practitioners took the approach of establishing a shared goal with the family of a safe future for Alyssa. They assessed the safety and risk to Alyssa holistically, engaged services, and made reflective and collaborative decisions. Caseworkers were open and upfront with the parents about their worries without making the parents defensive.

Practitioners developed a plan to support and monitor the family intensively. They were aware of heightened periods of stress for the parents during Alyssa's first three months. They talked about this with Alyssa's family and worked together to form safety plans that enlisted extended family members to take responsible, protective roles during these periods.

The collaborative work of FACS, other services and the family led to Alyssa remaining safe in her parents' care, with a number of services supporting the family and monitoring her progress.

Chapter 4: Improving the way FACS works with children and families

During 2016 and 2017 the NSW Government continued to implement broad reforms of the child protection and OOHC system in NSW. The reforms are aimed at ensuring sustained change and creating an accountable system, where client outcomes, strong evidence and needs-based supports are centred on children and families.

The NSW State Budget 2017–18 invested \$1.9 billion⁹² to protect and support NSW's most vulnerable children, young people and families. The total funding package across the next four years includes:

- \$148 million in new funding to support children with high needs in OOHC
- \$95 million for targeted early intervention to support parenting, youth and family support programs
- \$63 million in new funding for additional caseworkers and casework support workers
- \$90 million for new evidence-based models improving family preservation through the Multisystemic Therapy for Child Abuse and Neglect (MST-CAN[®]) and Functional Family Therapy through Child Welfare (FFT-CW[®]) programs to help at least 900 children a year in 15 priority locations.

Sitting alongside the government's reform agenda, the OSP has updated the *NSW FACS Care and Protection Practice Framework* – now renamed the *NSW Practice Framework* – to reflect FACS underlying values, practice approaches and mandates to guide how the department will work with vulnerable families.

4.1 Their Futures Matter

Their Futures Matter,⁹³ launched in November 2016, is the NSW Government's long-term strategy for improving outcomes for vulnerable children and families.

The strategy was informed by an independent review of the OOHC system, commissioned by the NSW Government. The review found while the current system was responding to immediate crisis, it wasn't addressing the complex needs of vulnerable children and families, improving outcomes or impacting on devastating cycles of intergenerational abuse and neglect. The review found this to be especially true for Aboriginal children, young people and families.

The review recommended a vision for whole of system reform to improve outcomes for vulnerable children and families by ensuring that:

- children are safe and supported to reach their potential
- vulnerable families receive help specific to their needs, to improve their outcomes and future wellbeing
- Aboriginal children and families have access to effective, culturally appropriate services to improve life opportunities.

The reform is different to those attempted before in key respects:

- it applies an investment approach to service design and delivery to guide investment and target services
- it uses data to identify the most vulnerable groups so we can prioritise their needs
- it introduces tailored support packages centred on children and families
- it establishes a single commissioning entity within FACS responsible for driving the reform process
- it aligns cross-government funding for vulnerable children and families.

⁹² See NSW Government Treasury (2017).

⁹³ See NSW Government (n.d.).

The overall strategy for *Their Future Matters* is delivered through:

- **needs-based supports** from wraparound support packages designed to meet the needs of vulnerable children and families
- **one connected system** from an independent commissioning entity that focuses on achieving better outcomes for vulnerable children and families
- **a smart system** that is sustainable and based on data and evidence.

4.1.1 Family preservation and restoration programs

In 2016–17 the NSW Government invested \$90 million across four years to July 2020 to help 900 children each year through intensive family preservation and restoration services aimed at keeping families together. Two intensive family preservation and restoration models were chosen: Multisystemic Therapy for Child Abuse and Neglect (MST-CAN[®]),⁹⁴ and Functional Family Therapy through Child Welfare (FFT-CW[®]).⁹⁵

Both models have already been shown to be successful with families internationally, and aim to reduce entries into OOHC, increase exits from OOHC, and respond to trauma and other underlying causes of child abuse and neglect.

MULTISYSTEMIC THERAPY FOR CHILD ABUSE AND NEGLECT

MST-CAN[®] provides intensive therapy to children and families, in cases where children (aged six to 17) are at high risk of being removed, or where the child has been recently taken and there is a plan to restore them to their parents. MST-CAN[®] is delivered in the home by a highly skilled psychologist, who is available to the family 24 hours a day, seven days a week, and can work with the family for up to nine months.

FUNCTIONAL FAMILY THERAPY THROUGH CHILD WELFARE

FFT-CW[®] is a home-based therapy-focused treatment model for high-risk families where physical abuse or neglect has been experienced. FFT-CW[®] therapeutic services can be provided to families in their homes or by other services in the community.

In August 2017, 11 service providers started delivering the two models in a number of priority locations across NSW:

- MST-CAN[®] will eventually be delivered at Coffs Harbour, Macarthur, Ingleburn, Edgeworth, Mayfield, Charlestown, Wyong, Tamworth and Dubbo CSCs.
- FFT-CW[®] will be delivered at Fairfield, Central Sydney, Lakemba, Burwood, Eastern Sydney, Central Sydney, St George, Edgeworth, Mayfield, Charlestown, St Marys, Wagga Wagga, Penrith, Nowra, Ulladulla, Macarthur, Ingleburn, Shell Harbour, Wollongong, Blacktown and Mt Druitt.

Fifty per cent of places in the MST-CAN[®] and FFT-CW[®] family services are dedicated to Aboriginal families. FACS is monitoring and evaluating the models thoroughly during implementation to help us to understand Aboriginal families' access to and engagement with the models, and to test the effectiveness for Aboriginal families who experience the models.

⁹⁴ Developed at the Medical University of South Carolina. See *Global Family Solutions* (2017).

⁹⁵ See *Functional Family Therapy* (2017).

4.2 Permanency Support Program

A key project arising from *Their Futures Matter* is the Permanency Support Program, which started on 1 October 2017. The Permanency Support Program is a key philosophical shift from a 'placement-based service' to a 'child and family centred service system' that focuses on the needs of children and their families and helps them to effect lasting change.

Based on the principles that every child should feel safe; should feel that they belong (to family and community); should have stability, certainty and opportunity; and have the best possible start to life, the Permanency Support Program is implementing a number of reform areas, some of which are still being developed.

New contracts under the Permanency Support Program now focus service providers on preparing children for permanent placements through restoration, guardianship or open adoption.⁹⁶

Contracted foster care, Aboriginal foster care and residential care is being reformed. Intensive Therapeutic Care (ITC), which includes services previously known as residential care, is undergoing a tender process with a stronger focus on therapeutic service delivery.

OOHC recommissioning is the first stage of a longer term vision for the government's recommissioning of services within a broader child permanency framework that will create a pathway for successive contract changes over time.

The four main components of the Permanency Support Program⁹⁷ are:

- building permanency and early intervention principles into casework
- working intensively with families and kin to support change
- renewing the way we recruit, develop and support people who care for children
- reforming our ITC system.

4.2.1 Building permanency and early intervention principles into casework

Case plans for children will focus on agencies working with families to keep children at home or, where that is not possible, finding a stable and secure option through guardianship or open adoption.

The case plan can include different packages based on the child or young person's individual needs, and not on their placement circumstances. To increase the flexibility of the system, a number of funding packages and targeted support packages can be mixed and matched to suit a child or young person's individual needs and achieve case plan goals.

Where a child or young person can't stay with family for safety and wellbeing reasons, short-term court orders (of up to two years) will be used to support the permanency goal of their case plan.

Permanency Support Coordinators will be placed in each district to oversee resource allocation, the connection of children and families to the services they need to achieve permanency within two years, and quality assurance around the implementation of initial case plans and other packages.

4.2.2 Working intensively with families and kin to support change

FACS will work to keep families together as much as possible, if a child or young person can safely remain with or return home to their birth family. We will also work with extended family and kin because we know the importance of keeping children connected to their family and community. We'll support

⁹⁶ Open adoption does not apply to Aboriginal children or young people.

⁹⁷ To learn more about the Permanency Support Program, see the FACS website URLs in the reference list.

family preservation in the first instance, using evidence-based tools like Family Group Conferencing and models like Family Finding.

Where it's suitable to restore a child or young person to their family, intensive support will be provided through MST-CAN® and FFT-CW® or other available services to ensure the pathway home for children is successful and meets their needs. Step-down support will be provided following the return of a child or young person to their family.

MST-CAN® and FFT-CW® will help reduce the need for children to be taken from their parents, increase the number of children who are returned to their parents or families, and respond to trauma and underlying causes of child abuse and neglect.

By reducing the number of children in OOHC, funds can be reinvested in the delivery of family strengthening and prevention services to strengthen the capacity of families to care for their children. This will create a stronger and more innovative service system in the longer term.

FAMILY GROUP CONFERENCING

Family group conferencing (FGC) is a family-focused, strengths-based form of alternative dispute resolution that aims to strengthen partnerships between family members and encourage greater parental decision-making and responsibility. FGC helps inform case planning and aims to provide an opportunity for families to develop their own plan to keep their children safe. It aims to:

- place children and families at the centre of planning and decision-making
- empower parents and families in decision-making about the safety and wellbeing of their children
- improve outcomes for children and young people by providing them with a stronger voice
- keep family together safely
- build respectful relationships through open communication.

FAMILY FINDING

Family Finding⁹⁸ is a model that seeks to connect children with family and other supportive adults who will love them and care about them now and throughout their lives. This is important for children whether they are at home with their families or if they have been taken into the care system.

Without these connections, children are vulnerable to experiencing isolation and loneliness. Family Finding is about the importance of emotional permanency for children and the sense of security and belonging that enduring relationships can provide. This in turn builds resilience and better prepares children for adulthood.

Work with urgency

Family Finding asks practitioners to urgently pursue meaningful, supportive and permanent relationships with loving and safe adults for children and young people. This means being persistent in finding new connections with family, and challenging the structural barriers that may stop us from developing or strengthening these relationships.

Seek permanent belonging

Family Finding encourages practitioners to think about 'permanency' as a state of 'permanent belonging' instead of just a legal perspective. This includes a child knowing about their history, and which adults they can go to for help and support.

Support family-driven processes

Family Finding recognises that families are disempowered when children are placed outside the family system. It addresses this potential harm by identifying the strengths and assets of each family member and finding ways that families can support and nurture their children. Family Finding encourages us to see families differently.

Develop clear goals

Family Finding has a strong focus on the values of empowerment, belonging and emotional permanency for children. It also involves the development of clear and definable goals that can be easily tracked through careful case planning.

4.2.3 Taking a new approach to the way we recruit, develop and support people who care for children

FACS values the work of foster, kinship and relative carers, and under the new Permanency Support Program their role is more important than ever in supporting each child or young person's pathway to permanency.

Together with the sector, and informed by the work of the services of Fostering NSW as well as Connecting Carers, FACS is co-designing a new approach to the recruitment, development and support of carers who can support a child's return home to their family, as well as guardians and people interested in adopting a child or young person from OOHC.

This new approach aims to clarify the different roles people can play to support vulnerable children and families, and where required, give more children a permanent home for life.

FACS and the sector will recruit enough preservation, restoration, emergency and respite carers so that children and families can be supported close to home and within their existing community where possible.

Where children can't remain with their family, we want to recruit more prospective guardians and adoptive parents. Every child or young person deserves to have a stable, nurturing and safe home. Guardianship and open adoption will give them this opportunity.

⁹⁸ See Campbell (2016).

For those interested in adopting a child or young person, the NSW Government is committed to streamlining the process. A means-tested adoption allowance will also help those who require financial assistance to meet the child's needs.

For the recruitment, development and support of carers of Aboriginal children, the focus will be on ensuring carers are trained and supported to provide culturally embedded therapeutic care.

4.2.4 Introducing Intensive Therapeutic Care

Many children in care have experienced trauma. To support their specific needs, FACS will keep a strong focus on recovery from trauma through an Intensive Therapeutic Care (ITC) system for children over 12 years who have been assessed as requiring intensive therapy.

ITC will be introduced to replace residential care through a two-stage tender process.

The ITC system will have a centralised referral pathway and use a broad assessment to determine if a child or young person should enter ITC if they can't be immediately supported in a family-based or foster care placement.

Under the model, short-term Intensive Therapeutic Transitional Care will be provided (for periods of up to 13 weeks) to help young people move into less intensive types of care.

The new approach will reduce the length of time children spend in intensive OOHC services by providing clear pathways to permanency.

To help ensure the ITC model functions in line with its intent, FACS will appoint and fund an independent 'intermediary' organisation. This organisation will support providers by:

- providing expert advice and consultancy services
- maintaining a knowledge bank of evidence-based therapeutic care
- promoting knowledge sharing across the sector
- offering learning and development activities
- creating a community of practice for therapeutic specialists.

4.3 Review of Aboriginal children and young people in out-of-home care

In 2016, the NSW Government committed to an independent review of the circumstances of 1152 Aboriginal children and young people who entered care in NSW between 1 July 2015 and 30 June 2016. These 1152 Aboriginal children represented more than 37 per cent of the children in care – a significant over-representation given only three per cent of the general population is Indigenous.

The review came about following advocacy by Grandmothers Against Removals⁹⁹ and others at the *Our Kids Our Way: Hearing the Voices of Aboriginal People* forum in August 2016. The (then) Minister for Family and Community Services committed to bring about change, starting with the independent review.

As discussed earlier in this chapter, the review is part of a wider NSW Government reform to address the complex needs of vulnerable children, young people and families, with \$90 million committed over the next four years for family preservation and restoration services.

In September 2016, Professor Megan Davis was appointed as independent chairperson of the *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW*.

The review will seek to understand the reasons for the high and increasing rate of Aboriginal children

⁹⁹ Formed in 2014, Grandmothers Against Removals is a group of Aboriginal families affected by child removal policies, that advocates to improve government policy responses to Aboriginal families.

entering care, and look at how the Aboriginal child placement principles have been applied. Professor Davis will make recommendations for strategies to reduce the number of Aboriginal children entering OOHC, increase restorations and permanency outcomes, and improve connections to family, culture and community for Aboriginal children in OOHC.

The review will look at systems, policies and practices, as well as the involvement of children, family, community, the service sector and carers in decision-making for Aboriginal children in OOHC.

In addition to considering the individual circumstances of the 1152 Aboriginal children who entered OOHC, in the later part of 2017 the review will also consult with communities, families, the OOHC sector, agencies and workers via District forums and meetings, yarning circles and personal discussions.

The review may also make recommendations to:

- address the causes of the high and increasing rates of Aboriginal and Torres Strait Islander children in care in NSW
- ensure the implementation of the statutory Aboriginal and Torres Strait Islander Child and Young People Placement Principles in NSW
- bring about changes to policies, practices and systems, based on what is learned from the individual reviews.

Professor Davis is scheduled to provide the Minister for Family and Community Services with her final review report on 30 April 2018.

4.4 NSW Practice Framework

In 2012, the OSP introduced the *NSW FACS Care and Protection Practice Framework*, at the time the first document of its kind in NSW. It provided FACS frontline staff with a shared identity and direction on the basics of good child protection practice; it also provided explicit role clarity to practitioners by articulating the endorsed principles, standards and approaches of FACS. In 2017, the OSP revised the framework. Launched by the FACS Secretary in September 2017, the *NSW Practice Framework*¹⁰⁰ takes the best of *Practice First*,¹⁰¹ and the best of our tools and brings them together into one amalgamated framework¹⁰² that the whole agency now works to.

The *NSW Practice Framework* provides an integrated reconceptualisation of the approach, values, standards, tools and rules that currently guide the NSW statutory child protection system. Clearly articulated mandates about how we approach our work are now available for every employee in FACS, every community partner and all the families we work with.

¹⁰⁰ The *NSW Practice Framework* is the new title given to the revised framework.

¹⁰¹ *Practice First* is a child protection service delivery model that aims to improve systems, practices and culture relating to assessment, decision-making and support for children at risk of significant harm (ROSH). The model strengthens caseworker skills and capability and reduces administrative burden so caseworkers can spend more time with clients, increasing family and partner agencies' participation in decision-making and improving caseworker satisfaction and retention. Developed by the OSP within FACS, *Practice First* has a strong emphasis on principles aligned with strengths-based and solution-focused work.

¹⁰² See NSW FACS (2017).

NSW PRACTICE FRAMEWORK

Practitioner mandate

We build relationships that are focused on children. We work hard to give dignity, partner with parents, families and communities, and use collective wisdom, skills and courage to keep children safe.

Leadership mandate

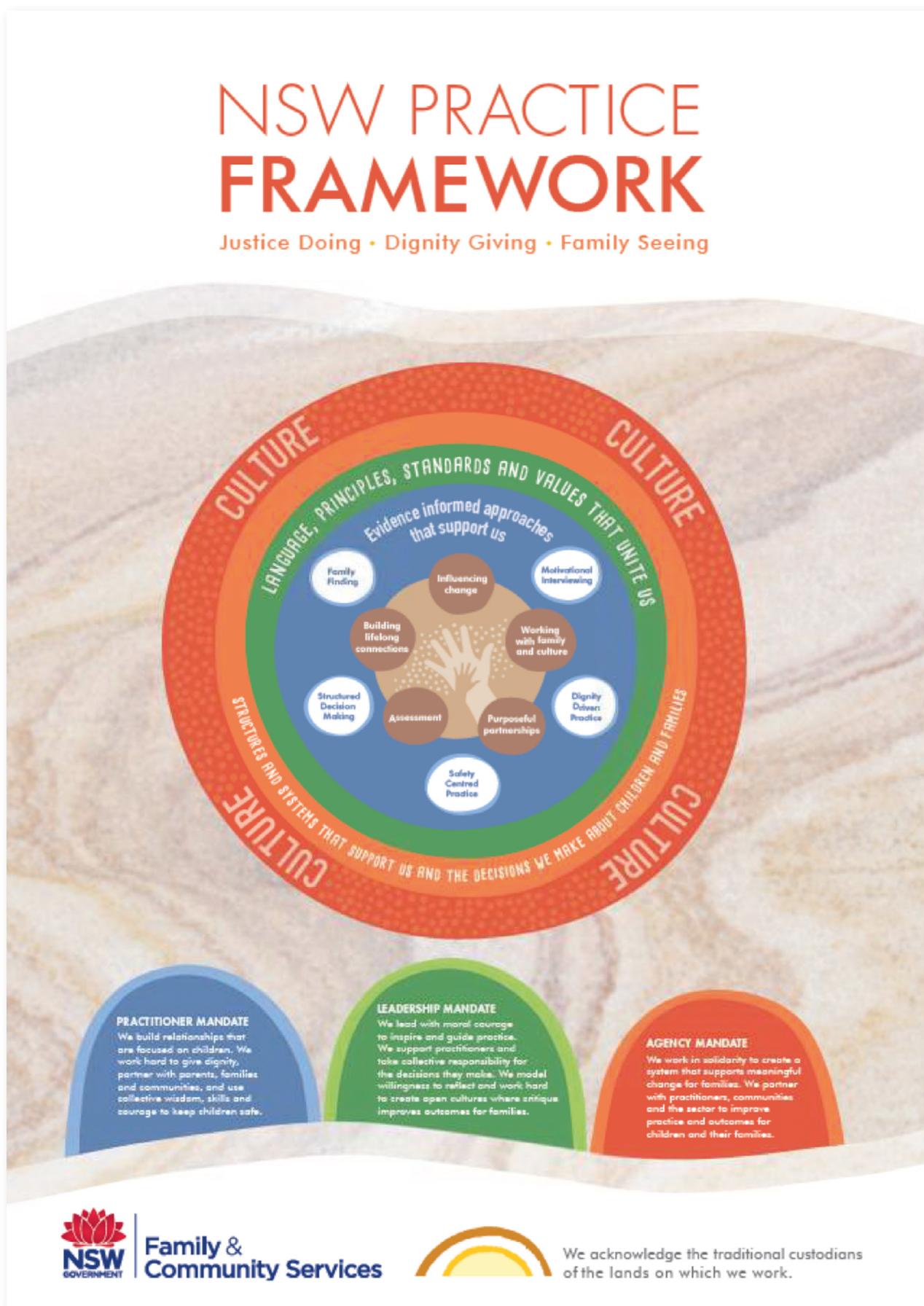
We lead with moral courage to inspire and guide practice. We support practitioners to take collective responsibility for the decisions they make. We model willingness to reflect and work hard to create open cultures where critique improves outcome for families.

Agency mandate

We work in solidarity to create a system that supports meaningful change for families. We partner with practitioners, communities and the sector to improve practice and outcomes for children and families.

The *NSW Practice Framework* also provides visibility of all initiatives to facilitate stronger sustained implementation of our approaches, showing their complementary nature and synergies. The *NSW Practice Framework* outlined in Figure 7 forms the practice base for our whole organisation towards integrated, quality, sustained family work. It shows in detail how we use skilful practice (assessment, influencing change, working with family and culture, partnering work, and building lifelong connections) and evidence-based approaches (Structured Decision Making, motivational interviewing, safety centred practice, dignity driven practice and family finding) to support all of our work with families.

Figure 7: The NSW Practice Framework



References and further reading

- Ashley, C. & Nixon, P. (Eds). (2007). *Family group conferences: Where next? Policies and practices for the future*. London: Family Rights Group.
- Australian Institute of Family Studies (AIFS). (2016). *Child deaths from abuse and neglect, CFCA resource sheet – May 2016*. Child Family Community Australia (CFCA). AIFS: Melbourne. Retrieved 18/08/17 <<https://aifs.gov.au/cfca/publications/child-deaths-abuse-and-neglect>>.
- Australian Institute of Health and Welfare (AIHW). (2017). *Child protection Australia 2015–2016*. AIHW: Canberra.
- Australian Multicultural Foundation Aged Care Training Institute (MACTI). (2002). *Dying, death and grieving: A cultural perspective*. Conference report. Melbourne: Australian Multicultural Foundation. Retrieved 19/10/17 <http://amf.net.au/library/uploads/files/Dying_Death_and_Grief_Conf.pdf>.
- beyondblue. (2016). *beyondblue*. Melbourne: beyondblue. Retrieved 19/10/17 <www.beyondblue.org.au>.
- Cameron, M. (2008). *The effect of loss of a child on subsequent parenting: A review of the literature*. Conference papers – American Sociological Association, 1.
- Campbell, K. (2016). *Finding families: Why children need families and how we find them*. Research to Practice seminar notes. Sydney: NSW FACS.
- Christiansen, D. M. (2017). Posttraumatic stress disorder in parents following infant death: A systematic review. *Clinical Psychology Review*, 60.
- Damashek, A. & Bonner, B. (2010). Factors related to sibling removal after a child maltreatment fatality. *Child Abuse and Neglect*, 34(8), 563–569.
- Davies, R. (2005). Mothers' stories of loss: Their need to be with their dying child and their child's body after death. *Journal of Child Health Care*, 9(4), 288–300.
- Denhup, C. Y. (2017). A new state of being: The lived experience of parental bereavement. *Omega: Journal of Death and Dying*, 74(3), 345–360.
- Department of Human Services. (2010). *Sibling safety policy*. Retrieved 18/08/17 <http://docsonline.dcs.gov.au/__data/assets/pdf_file/0011/286787/sibling_safety.pdf>.
- Department of Prime Minister and Cabinet. (2014). *Aboriginal and Torres Strait Islander Health Performance Framework 2014 report*. Canberra: DPC.
- Doka, K. J. (Ed.). (2002). *Disenfranchised grief: New directions, challenges, and strategies for practice*. Champaign, IL: Research Press.
- Escobar-Chew, A. R., Carolan, M. & Burns-Jager, K. (2015). Connecting trauma and health for mothers in the child welfare system. *Journal of Feminist Family Therapy*, 27(2), 47–71.
- Frederico, M., Jackson, A. & Dwyer, J. (2014). Child protection and cross-sector practice: An analysis of child death reviews to inform practice when multiple parental risk factors are present. *Child Abuse Review Psychology*, 23(2), 104–115.
- Functional Family Therapy. (2017). *FFT Child Welfare*. Seattle: Functional Family Therapy. Retrieved 18/08/17 <<http://www.fftllc.com/fft-child-welfare/>>.
- Garstang, J., Griffiths, F. & Sidebotham, P. (2014). What do bereaved parents want from professionals after the sudden death of their child: A systematic review of the literature. *BMC Paediatrics*, 14(1), 269.
- Global Family Solutions. (2017). *Multisystemic Therapy for Child Abuse and Neglect*. Retrieved 18/08/17 <www.mstcan.com/>.

- Harper, M., O'Connor, R., Dickson, A. & O'Carroll, R. (2011). Mothers continuing bonds and ambivalence to personal mortality after the death of their child: An interpretative phenomenological analysis. *Psychology, Health & Medicine*, 16(2), 203–214.
- Harper, M., O'Connor, R. & O'Carroll, R. (2014). Factors associated with grief and depression following the loss of a child: A multivariate analysis. *Psychology, Health & Medicine*, 19(3), 247–252.
- Hazzard, A., Weston, J. & Gutterres, C. (1992). After a child's death: Factors related to parental bereavement. *Journal of Developmental & Behavioral Pediatrics*, 13(1), 24–30.
- International Work Group on Death, Dying and Bereavement (IWG). (2013). *When does a broken heart become a mental disorder?* Victoria, British Columbia: IWG, Retrieved 18/08/17 <https://www.compassionatefriendsvictoria.org.au/wpcontent/uploads/2016/07/IWG_Grief_Statement_20131.pdf>.
- Johnson, S. B., Sudhinaraset, M. & Blum, R. (2010). Neuromaturation and adolescent risk taking: Why development is not determinism. *Journal of Adolescent Research*, 2, 4–24.
- Kilves, K. (2010). Child suicide, family environment, and economic crisis. *Crisis*, 31(3), 115–117.
- Klass, D., Silverman, P. R. & Nickman, S. (Eds.). (2014). *Continuing bonds: New understandings of grief*. Philadelphia: Taylor & Francis.
- McKissock, D. & McKissock, M. (2012). *Coping with grief* (4th ed.). Melbourne: HarperCollins Australia.
- Munro, E. (1996). Avoidable and unavoidable mistakes in child protection work. *British Journal of Social Work*, 26(6), 793–808.
- Munro, E. (2011). *How organisations can learn to reduce risk to children*. Sydney, NSW FACS. Retrieved 18/08/17 <http://www.facs.nsw.gov.au/__data/assets/pdf_file/0018/251415/how_reduce_risk.pdf>.
- National Centre for Childhood Grief. (2013). *Friends indeed*. Newsletter (5th ed.), 1–6. Sydney: NCCG. Retrieved 18/08/17 <<https://childhoodgrief.org.au/wp-content/uploads/2017/03/NCCG-Newsletter-Final-2013.pdf>>.
- National Centre for Childhood Grief. (2017a). *Welcome*. Sydney: NCCG. Retrieved 18/08/17 <<https://childhoodgrief.org.au/>>.
- National Centre for Childhood Grief. (2017b). *Kids and grief : How we can help*. Sydney: NCCG. Retrieved 18/08/17 <<https://childhoodgrief.org.au/how-we-help/kids-and-grief/>>.
- National Child Traumatic Stress Network. (2016). *Sibling loss fact sheet: Sibling death and childhood*. Los Angeles: NCTSN. Retrieved 18/08/17 <www.NCTSN.org>.
- NSW Attorney General & Justice. (2016). *Coronial Information and Support Program (CSP)*. Sydney: NSW Attorney General & Justice. Retrieved 19/10/17 <www.coroners.justice.nsw.gov.au/Documents/CISP%20brochure.pdf>.
- NSW Child Death Review Team. (2014). *Causes of death of children with a child protection history 2002–2011: A special report to parliament under s.34H of the Community Services (Complaints, Reviews and Monitoring) Act 1993*. Sydney: NSW Ombudsman.
- NSW Child Death Review Team. (2015). *Submission to the Independent Review of Swimming Pool Barrier Requirements in NSW*. Sydney: NSW Ombudsman. Retrieved 18/08/17 <<https://www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-death-review-team/cdrt-submission-to-the-independent-review-of-swimming-pool-barrier-requirements-int-nsw-october-2015>>.
- NSW Department of Justice. (2016). *Post mortem*. Sydney: NSW Department of Justice. Retrieved 19/10/17 <www.coroners.justice.nsw.gov.au/Pages/what_happens_process/post_mortem/post_mortem.aspx>.
- NSW Family and Community Services. (2012). *Care and protection practice standards*. Sydney: NSW FACS.

NSW Family and Community Services. (2014). *Care and protection practice framework*. Sydney: NSW FACS.

NSW Family and Community Services. (2015). *Child deaths 2014 annual report: Learning to improve services*. Sydney: NSW FACS. Retrieved 18/08/17 <https://www.facs.nsw.gov.au/about_us/news/2015/child-deaths-2014-annual-report>.

NSW Family and Community Services. (2016a). *Child deaths 2015 annual report: Learning to improve services*. Sydney: NSW FACS. Retrieved 18/08/17 <http://www.community.nsw.gov.au/__data/assets/file/0003/387030/child_deaths_report_2015_fullreport.pdf>.

NSW Family and Community Services. (2016b). *Critical incidents: Information and resources for out-of-home care non-government organisations*. Sydney: NSW FACS. Retrieved 18/08/17 <<http://www.community.nsw.gov.au/parents,-carers-and-families/out-of-home-care-transition/policies,-procedures-and-tools/critical-incident>>.

NSW Family and Community Services. (2016c). *Shining a light on good practice in 2016*. Sydney: NSW FACS.

NSW Family and Community Services. (2016d). *Statistical report 2014–15*. Sydney: NSW FACS. Retrieved 18/08/17 <http://www.facs.nsw.gov.au/__data/assets/file/0006/373641/FACS-Statistical-Report-14-15.pdf>.

NSW Family and Community Services. (2016e). *Statistical report 2015–16*. Sydney: NSW FACS. Retrieved 18/08/17 <https://www.facs.nsw.gov.au/__data/assets/pdf_file/0003/419277/FACS-Statistical-Report-2015-16-V10.pdf>.

NSW Family and Community Services. (2017). *NSW Practice Framework*. Sydney: NSW FACS.

NSW Government. (n.d.). *Their Futures Matter*. Sydney: NSW Government. Retrieved 18/08/17 <www.theirfuturesmatter.nsw.gov.au/>.

NSW Government Treasury. (2017). *NSW Budget 2017–18 – Budget Papers*. Budget Paper 3, p. 3-2. Sydney: NSW Treasury. Retrieved 18/08/17 <<https://www.budget.nsw.gov.au/nsw-budget-2017-18-budget-papers>>.

NSW Health. (n.d.). *CT scan (computerised tomography)*. Sydney: The Sydney Children's Hospital Network. Retrieved 19/10/17 <<https://www.schn.health.nsw.gov.au/parents-and-carers/fact-sheets/ct-scan-computerised-tomography>>.

NSW Health. (2015). *Death and dying in Aboriginal and Torres Strait Islander culture (Sorry business)*. Sydney: NSW Health. Retrieved 18/08/17 <http://www.nslhd.health.nsw.gov.au/Services/Directory/Documents/Death%20and%20Dying%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20Culture_Sorry%20Business.pdf>.

NSW Health. (2017). *Safe sleeping for your baby*. Sydney: NSW FACS. Retrieved 18/08/17 <<http://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Publications/safe-sleeping-for-your-baby.pdf>>.

NSW Ombudsman. (2017). *Report of reviewable deaths 2014 and 2015. Volume 1: Child deaths*. Sydney: NSW Ombudsman.

NSW Police Force. (2016). *NSW Police Force Handbook*. Sydney: NSW Police Force. Retrieved 19/10/17 <www.police.nsw.gov.au/__data/assets/pdf_file/0009/197469/NSW_Police_Handbook.pdf>.

Office of the Chief Health Officer. (2016). *End of life care and decision-making – Guidelines*. Sydney: NSW Health.

Packman, W., Horsley, H., Davies, B. & Kramer, R. (2006). Sibling bereavement and continuing bonds. *Death Studies*, 30(9), 817–841.

Pearlman, L. A., Wortman, C. B., Feuer, C. A., Farber, C. H. & Rando, T. A. (2014). *Treating traumatic bereavement: A practitioner's guide*. New York: Guilford.

- Queensland University of Technology (QUT). (2017). *Children and end of life decision-making*. Brisbane: QUT. Retrieved 18/08/17 <<https://end-of-life.qut.edu.au/stopping-treatment/children>>.
- Red Nose. (2017). *Red Nose: Saving little lives*. Melbourne: Red Nose. Retrieved 18/08/17 <<https://rednose.com.au/>>.
- Reimer, E. C. (2013). Relationship-based practice with families where child neglect is an issue: Putting relationship development under the microscope. *Australian Social Work*, 66(3), 455–470.
- Royal Life Saving Society – Australia. (2015). *National drowning report 2015*. Sydney: RLS. Retrieved 18/08/17 <www.royallifesaving.com.au/__data/assets/pdf_file/0006/14559/RLS_NDR2015_Report_LR.pdf>.
- Royal Life Saving Society – Australia. (n.d.). *Keep Watch*. Sydney: RLS. Retrieved 18/08/17 <www.royallifesaving.com.au/programs/keep-watch-toddler-drowning-prevention-program>.
- Stroebe, M. & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies*, 23(3), 197–224.
- Turnell, A. & Edwards, S. (1999). *Signs of safety: A solution and safety oriented approach to child protection*. New York: W. W. Norton.
- Ustundag, M., Larkin, M., Harris, G. & Blissett, J. (2015). Mother's accounts of their stillbirth experiences and of their subsequent relationships with their living infant: An interpretative phenomenological analysis. *Bio Medical Central Pregnancy and Childbirth*, 15, 263.
- Victorian Department of Human Services. (2014). *Leading practice: A resource guide for child protection leaders* (2nd ed.). Melbourne: Victorian Department of Human Services. Retrieved 18/08/17 <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0011/583544/Leading-practice-resource-guide-for-child-protection-leaders-0214.pdf>.
- Vollmann, S. R. (2014). A legacy of loss: Stories of replacement dynamics and the subsequent child. *Omega: Journal of Death and Dying*, 69(3), 219–247.
- Youngblut, J., Brooten, D., Cantwell, P., del Moral, T. & Totapally, B. (2013). Parent health and functioning 13 months after infant or child NICU/PICU death. *Pediatrics*, 132(5). Retrieved 19/09/17 <<http://pediatrics.aappublications.org/>>.

FACS Casework Practice intranet documents

An effective first response

<<http://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/mental-health/modules/safety-assessment-plan#chapter-400972>>

Child Sexual Assault Kit

<<http://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/child-sexual-abuse>>

Culturally responsive practice with diverse communities

<<http://caseworkpractice.intranet.facs.nsw.gov.au/practice-advice/working-with-children-and-families/culturally-responsive-practice-with-diverse-communities>>

Domestic Violence Kit

<<http://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/domestic-and-family-violence>>

Health needs of children in out-of-home care: Practice mandate

<<http://caseworkpractice.intranet.facs.nsw.gov.au/mandates/children-in-care/health-needs-of-children-in-oohc>>

Safe sleeping

<<http://caseworkpractice.intranet.facs.nsw.gov.au/download?file=335432>>

Sibling safety: Practice mandate

<<http://caseworkpractice.intranet.facs.nsw.gov.au/mandates/child-protection/sibling-safety>>

Using the pre-assessment consultation (PAC) purposefully

<<http://caseworkpractice.intranet.facs.nsw.gov.au/support/practice-kits/alcohol-and-other-drugs/modules/safety-assessment-safety-planning#chapter-407670>>

Water safety

<http://caseworkpractice.intranet.facs.nsw.gov.au/documents/Other-assets/forms2/for-parents/water-safety/_nocache>

Working with Aboriginal people and communities: A practice resource

<http://caseworkpractice.intranet.facs.nsw.gov.au/__data/assets/pdf_file/0011/334289/Working-with-Aboriginal-people-a-practice-resource.pdf>

Permanency Support Program URLs

Intensive Therapeutic Care

<<http://www.community.nsw.gov.au/about-us/key-reforms/permanency-support-program/intensive-therapeutic-care>>

Permanency in casework

<<http://www.community.nsw.gov.au/about-us/key-reforms/permanency-support-program/permanency-in-casework>>

Working with families

<<http://www.community.nsw.gov.au/about-us/key-reforms/permanency-support-program/working-with-families>>

Appendix 1: Counselling and support services

| Service | Description | Contact |
|--|---|---|
| Child Protection Helpline | Report suspected child abuse or neglect to FACS | 132 111 |
| Aboriginal Counselling Services (ACS) | Provides crisis intervention and therapeutic counselling for Aboriginal families, individuals and communities within NSW | 0410 539 905 |
| Aboriginal Medical Service | Provides comprehensive health care to the Aboriginal community | Find local contacts at www.ahmrc.org.au |
| Red Nose NSW and Victoria | Provides 24/7 bereavement support to families who have suffered the loss of a baby | 1300 308 307 or visit https://rednosegriefandloss.com.au/ |
| NALAG Centre for Grief and Loss | Provides free face-to-face and telephone loss and grief support | (02) 6882 9222 or visit www.nalag.org.au/ |
| Lifeline | Provides 24/7 telephone crisis support and suicide prevention services | 13 11 14 or visit www.lifeline.org.au/ |
| National Centre for Childhood Grief | Free counselling for bereaved children; counselling also provided for bereaved adults, parents and caregivers (fee involved for this service) | 1300 654 556 or visit https://childhoodgrief.org.au/ |
| Department of Forensic Medicine | Provides information, support and counselling for relatives and friends of the deceased person for deaths being investigated by the Coroner | (02) 8584 7800 |
| Suicide Call Back Service | Free 24/7 phone, video and online counselling for anyone affected by suicide | 1300 659 467 |
| The Compassionate Friends | Self-help organisation offering friendship and understanding to bereaved parents, siblings and grandparents after the death of a child and fostering the physical and emotional health of bereaved parents and their surviving children | 1800 671 621 or visit www.tcfnsw.org.au/ |
| The Australian Child and Adolescent Trauma Loss and Grief Network | Resources to help caregivers understand and respond to the diverse needs of children and adolescents experiencing trauma, loss and grief | https://tgn.anu.edu.au/ |
| Kids Helpline | Telephone counselling | 1800 55 1800 or visit https://kidshelpline.com.au/ |

Appendix 2: Children's understanding of death

Children's understanding of death and reactions to grief

| Age | Understanding of death | Common grief reactions | Traumatic grief reactions |
|-------------------------------------|---|--|---|
| Preschool and young children | <ul style="list-style-type: none"> - Do not understand that death is final - May think that they will see the person again or that the person can come back to life - May think it was their fault that the person died | <ul style="list-style-type: none"> - May become upset when their routines change - May get worried or fussy when separated from their usual caregivers and may be clingy and want extra attention - May express fears, sadness and confusion by having nightmares or tantrums, being withdrawn, or regressing to earlier behaviours | <ul style="list-style-type: none"> - May repetitively engage in play about death or the person who died - May have problems getting back on schedule or meeting developmental milestones - May have difficulty being comforted |
| School-age children | <ul style="list-style-type: none"> - Gradually gain a more mature understanding of death - Begin to realise that death is final and that people do not come back to life - May have scary beliefs about death, like believing in the 'boogie man' who comes for the person | <ul style="list-style-type: none"> - May ask lots of questions about how the person died and about what death means - May display distress and sadness in ways that are not always clear, like being irritable and easily angered - May avoid spending time with others - May have physical complaints (headaches and stomach-aches) - May have trouble sleeping - May have problems at school - May have no reaction at all - May dream of events related to the death or war - May want to call home during the school day - May reject old friends and seek new friends who have experienced a similar loss | <ul style="list-style-type: none"> - May repeatedly talk or play about the death - May have nightmares about the death - May become withdrawn, hide feelings (especially guilt), and avoid talking about the person or about places and/or things related to the death - May avoid reminders of the person (e.g. may avoid watching TV news, may refuse to attend the funeral or visit the cemetery) - May become jumpy, extra alert, or nervous - May have difficulty concentrating on homework or class work, or may suffer a decline in grades - May worry excessively about their health, their parents' health, or the health and safety of other people - May act out and become the 'class clown' or 'bully' |
| Teenagers | <ul style="list-style-type: none"> - Have a full understanding of death | <ul style="list-style-type: none"> - May have similar grief reactions to those of school-age children when at home, with friends and at school - May withdraw, become sad or lose interest in activities - May act out, have trouble in school, or engage in risky behaviour - May feel guilt and shame related to the death - May worry about the future - May hide their true feelings | <ul style="list-style-type: none"> - May have similar traumatic grief reactions to those of school-age children - May avoid interpersonal and social situations such as dating - May use drugs or alcohol to deal with negative feelings related to death - May talk of wanting to harm themselves and express thoughts of revenge or worries about the future - May have low self-esteem because they feel that their family is now 'different' or because they feel different from their peers |

Glossary

Aboriginal

FACS recognises Aboriginal people as the original inhabitants of NSW. The term 'Aboriginal' in this report refers to the First Nations people of NSW. FACS also acknowledges that Torres Strait Islander people are among the First Nations of Australia.

Abuse

The abuse of a child or young person can refer to different types of maltreatment. It includes assault (including sexual assault), ill-treatment, neglect and exposing the child or young person to behaviour that might cause psychological harm, whether or not, in any case, with the consent of the child.

Alcohol and/or drug misuse

A significant substance abuse problem that interferes with a parent's daily functioning, and the substance abuse problem negatively impacts on his/her care and supervision of the child or young person to the extent that there is risk of significant abuse.

Authorised carer

A person who is authorised as a carer by a designated agency.

Case closure

Case closure is a considered casework decision that signals the end of FACS involvement with a matter.

Case plan

A case plan is a document that sets out what action will be taken to enhance the child or young person's safety, welfare and wellbeing.

Casework

Casework is the implementation of the case plan and associated tasks.

Caseworker

A FACS officer responsible for working with children, young people and their families, and other agencies in child protection, out-of-home care (OOHC) and early intervention. Caseworkers have day-to-day case coordination responsibilities. Caseworkers report to a Manager Casework.

Child

Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a child as a person under the age of 16 years.

Child Protection Helpline

The Child Protection Helpline provides a centralised system for receiving reports about unborn children, children and young people who may be at risk of significant harm (ROSH). It operates 24 hours a day, seven days a week.

Child Wellbeing Unit (CWU)

CWUs were established in NSW Health, the NSW Police Force, the NSW Department of Education and Communities and the NSW Department of Family and Community Services. CWUs assist mandatory reporters in government agencies to ensure all concerns that reach the threshold of risk of significant harm (ROSH) are reported to the Child Protection Helpline. Concerns that do not meet the new threshold are referred to alternative services within that agency, or in other organisations, which could support the family.

Children's Court

The court designated to hear care applications and criminal proceedings concerning children and young people in NSW.

Domestic violence

Violence between two people who are, or have been in the past, in a domestic relationship. The perpetrator of this violence can cause fear, and physical and psychological harm. Domestic violence is usually committed by men against women within heterosexual relationships, but can also be committed by women against men, and can occur within same-sex relationships. Domestic violence can have a profound negative effect on children and young people.

Engagement

An ongoing and dynamic process of attracting and holding the interest of a person in order to build an effective and collaborative relationship.

FACS Community Services Centre (CSC)

Locally based community services offices. There are 82 CSCs across NSW.

Key Information and Directory System (KIDS)

The FACS electronic system for keeping records and plans about children, young people and their families.

Manager Casework

A Manager Casework provides direct supervision and support to a team of FACS caseworkers.

Mandatory reporter

A person who, in the course of their professional or other paid employment, delivers health care, welfare, education, children's services, residential services or law enforcement wholly or partly to children, or a person who holds a management position in an organisation, the duties of which include direct responsibility for or direct supervision of the provision of health care, welfare, education, children's services, residential services or law enforcement wholly or partly to children. If a mandatory reporter has reasonable grounds to suspect that a child is at risk of significant harm (ROSH) and those grounds arise during the course of or from the person's work, it is the duty of the person to report to FACS as soon as practicable, the name or a description of the child and the grounds for suspecting that the child is at risk of significant harm (ROSH). This is outlined in Section 27 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Medical examination

Pursuant to Section 173 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), if the Secretary of FACS or a police officer believes on reasonable grounds that a child is in need of care and protection, the Secretary or the police officer may serve a notice naming or describing the child requiring the child to be forthwith presented to a medical practitioner specified or described in the notice at a hospital or some other place so specified for the purpose of the child being medically examined. The notice is to be served on the person (whether or not a parent of the child) who appears to the Secretary or the police officer to have the care of the child for the time being.

Mental health concerns

A mental health problem or diagnosed mental illness that interferes with a parent's daily functioning, and the mental health issue or diagnosed mental illness negatively impacts his/her care and supervision of the child or young person to the extent that there is risk of significant harm (ROSH).

Neglect

Neglect means that the child or young person's basic needs (e.g. supervision, medical care, nutrition, shelter) have not been met, or are at risk of not being met, to such an extent that it can reasonably be expected to produce a substantial and demonstrably adverse impact on the child or young person's safety, welfare or wellbeing. This lack of care could be constituted by a single act or omission or a pattern of acts or omissions.

Order

An order of a court or an administrative order.

Out-of-home care (OOHC)

For the purposes of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), out-of-home care (OOHC) means residential care and control of a child or young person that is provided by a person other than a parent of the child or young person, and at a place other than the usual home of the child or young person. There are three types of OOHC provided for in the *Children and Young Persons (Care and Protection) Act 1998*: statutory OOHC (Section 135A), supported OOHC (Section 135B) and voluntary OOHC (Section 135C).

Parental responsibility

In relation to a child or young person, means all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children.

Parental responsibility to the Minister

An order of the Children's Court placing the child or young person in the parental responsibility of the Minister under Section 79(1)(b) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW).

Physical abuse or ill-treatment

Physical abuse or ill-treatment is physical harm to a child or young person that is caused by the non-accidental actions of a parent, caregiver or other person responsible for the child or young person.

Prenatal report

The *Children and Young Persons (Care and Protection) Act 1998* (NSW) allows for prenatal reports to be made to FACS under Section 25 where a person has reasonable grounds to suspect an unborn child may be at risk of significant harm (ROSH) after birth.

Removal

The action by an authorised FACS officer or NSW Police Force officer to take a child or young person from a situation of immediate risk of serious harm and to place the child or young person in the care responsibility of the Secretary.

Report

A report made to FACS, usually via the Child Protection Helpline, to convey a concern about a child or young person who may be at risk of significant harm (ROSH).

Reporter

Any person who conveys information to FACS concerning their reasonable grounds to suspect that a child, young person or unborn child (once born) is at risk of significant harm (ROSH).

Restoration

When a child returns to live in the care of a parent or parents for the long term.

Risk of harm assessment

A process that requires the gathering and analysis of information to make decisions about the immediate safety and current and future risk of harm to the child or young person.

Risk of significant harm (ROSH)

For the purposes of Section 23 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) a child or young person is at risk of significant harm (ROSH) if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of any one or more of the following circumstances:

- (a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met
- (b) the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care
- (b1) in the case of a child or young person who is required to attend school in accordance with the *Education Act 1990* (NSW) – the parents or other caregivers have not arranged and are unable

or unwilling to arrange for the child or young person to receive an education in accordance with that Act

- (c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated
- (d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm
- (e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm
- (f) the child was the subject of a prenatal report under Section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report.

Risk-taking behaviours

Risk-taking behaviours include:

- suicide attempts or ideation
- self-harm
- engaging in criminal activities
- gang association and/or membership
- dealing drugs
- drug, alcohol and/or solvent use
- engaging in unsafe sex
- prostitution.

Safety and risk assessment (SARA)

SARA is a SDM[®] system for assessing risk. The goals of the system are to determine the safety of, and risk to children and young people through a structured process of information gathering and analysis. This is intended to produce more methodical and thorough assessments. SARA includes three distinct tools: Safety Assessment, Risk Assessment and Risk Reassessment.

Sexual abuse or ill-treatment

This is any sexual act or threat to a child or young person which causes that child or young person harm, or to be frightened or fearful. Coercion, which may be physical or psychological, is intrinsic to child sexual assault and differentiates such assault from consensual peer sexual activity.

Structured Decision Making (SDM[®])

SDM[®] aims to achieve greater consistency in assessments and support professional judgement in decision-making. The SDM[®] process structures decisions at several key points in case processing through use of assessment tools and decision guidelines.

Supervision

Professional supervision is a process by which the supervisor is given responsibility by the organisation to work with the supervisee in order to meet certain organisational, professional and personal objectives which together promote the best outcomes for children, young people and their families.

Supported care allowance

Financial support provided by FACS to relative/kin carers where there is no legal order. To be eligible for a supported care allowance, FACS must form an opinion that the child or young person is in need of care and protection. An annual review must occur to determine whether restoration is possible and, if not, how the parenting needs of the child are to be met, and whether a care application should be made to reallocate parental responsibility.

Triage and assessment practice guidelines

The practice guidelines describe the process of triaging risk of significant harm (ROSH) events and non-ROSH information at CSCs and outline the minimum practice required by CSCs when a ROSH event and non-ROSH information is received.

Weekly allocation meeting (WAM)

Weekly allocation meetings (WAM) are a state-wide procedure. Managers in all CSCs meet weekly to review new reports that cannot be allocated due to insufficient resources.

Young person

Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a young person as a person who is aged 16 years or above but who is under the age of 18 years.

Published by

Department of Family and Community Services

www.facs.nsw.gov.au

If you think a child or young person is at risk of significant harm, contact the Child Protection Helpline on 132 111.

ISSN 1839-8375

© Copyright, Department of Family and Community Services 2017

